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ABSTRACT

The curriculum guide for nursing occupations is one of five guides written and field tested in a project to develop statewide articulated competency-based curricula in selected vocational education programs. Following an introductory section giving the philosophy, background, and recommendations for nursing education, the 82 study units are arranged under the following general headings: The Nursing Process, Fundamentals of Nursing, Medical-Surgical Nursing, Maternal and Child Health Nursing, and Advanced Nursing of Adults and Children. For each unit, the terminal objective is stated and the performance objectives and criterion-referenced measures are listed. Intended to provide training for the nurses aide, licensed practical nurse, and the associate degree registered nurse, exit points are indicated for the first two occupations after successful completion of the required units. A bibliography is included. Appended is a 32-page excerpt of the American Nurses' Association Standards of Nursing Practice giving the rationale and assessment factors for each standard. The standards served as the major criteria for the evaluation of overall performance in the client care setting. (BG)

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Final Report

Project No. V0258VZ
Grant No. OEG-0-74-1744

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A STUDY FOR THE ARTICULATION OF COMPETENCY-BASED CURRICULA FOR THE COORDINATION OF VOCATIONAL-TECHNICAL EDUCATION PROGRAMS IN LOUISIANA

May 1976

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Office of Education

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Competency-Based Curriculum for Articulated Programs in Nursing Occupations

Volume V of six volumes

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U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE

Office of Education

National Center for Educational Research and Development

VT 102 842

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PURPOSE OF THE STUDY

The Bureau of Vocational Education, Louisiana State Department of Education was awarded a grant to make a study for the articulation of competency-based curricula for the coordination of selected vocational-technical education programs. The five areas selected for study and development of competency-based curricula were: (1) Air-conditioning/ Refrigeration, (2) Drafting, (3) Electronics, (4) Nursing, and (5) Office Occupations.

A team of writers worked during the Summer of 1975 developing curricula or guides for teachers on the three institutional levels: Secondary, Post-Secondary, Vocational-Technical, and Associate Degree programs on the collegiate level.

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COMPETENCY-BASED CURRICULUM
FOR
ARTICULATED PROGRAMS
IN
NURSING OCCUPATIONS

EXIT POINTS:

Nurse Aide

The student may exit after successful completion of Unit 41 as a Nurse Aide.

Licensed Practical Nurse

The student may exit after completion of Unit 77 and must successfully pass State Board Examination in order to qualify for Licensed Practical Nurse.

Associate Degree Registered Nurse

The student must complete all of the outlined units and successfully pass State Board Examination in order to qualify for Associate Degree Registered Nurse.

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PHILOSOPHY

Health care has been recognized as an important part of society since early civilization. An introduction to the basic needs for promoting and maintaining health is discussed in the elementary years. This should have already been bolstered by training in the home concerning the effects upon human growth and development of surroundings, diet, rest and exercise.

Not every person can be trained to deliver health care in the great complexity of areas where there is a need for such care, nor would they desire to be, but many persons can perform successfully, comfortably, and happily in an area where their talents may be developed and utilized. This should be a stimulus for preparing a curriculum of training that is progressive from the basic to the advanced and from the beginning tasks that can be done effectively in designated health care areas prior to the gaining of the intricate knowledge needed in other areas of health care.

The coordination, correlation and cooperation of the educational system and educators could produce the format by which the health needs of all persons could be met with greater efficiency and individual career goals, that many times are thwarted by lack of these elements, could be realized.

The indirect course that has traditionally been required to ascend the career ladder in the health care system has hindered the effectiveness in the system and prohibited many interested learners due to length of time involved, costs, and intolerance to duplication of learning activities.

Since the establishment of career exploration and skill centers in the public school system of Louisiana, the correlation of educational programs has not been sufficient for the movement of students from this level to the post-secondary vocational areas and/or to the state colleges and universities. We should begin and proceed with all deligence and determination to establish a cooperative articulated system of education in all possible areas.

Criterion should be determined and a curriculum devised that would provide a comfortable and educationally sound ascension for the capable and aggressive student from the Nurse Aide program at the secondary or vocational-technical level to the Associate Degree Registered Nurse level of the community college or university.

INTRODUCTION

The health care delivery system of the United States faces serious challenge due to the growing shortages of credentialed personnel in high level professional positions. There has been a proliferation of credentialed health care occupations which overlap and duplicate functions. "In 1970 there were forty curriculums designed to prepare personnel at less-than-baccalaurate level in eighteen different specialty areas which were fundable through vocational education."[1] Most of the occupations are dead-end without opportunity to utilize knowledge and skills toward upward progression. The burden of education falls on the individual without assurance that education is relevant or fully utilized.

The greatest social cost in the health care industry is the training and education of manpower. Schools with properly trained, skilled, professional personnel are in short supply.

The existence of four levels of nursing with varying demands and time requirements has made it difficult for transfer of credit from one type of program to another. Even among similar types of programs, granting of credit upon transfer from school to school has been difficult. Satisfactory methods for advanced placement have been slow to develop. Institutional philosophies recognizing previous education has in the past been an uncommon phenomenon.

In the latest effort to study the needs of nursing and its relationship to the other professions in the health care delivery system on a national level, Lysaught reports "The most difficult problem which confronts the nursing education system and the students who choose to prepare for nursing is the absence of articulation between the various components of the system."[2]

January 17, 1970, the National Commission for the Study of Nursing and Nursing Education recommended that public and private agencies plus federal and state governments appropriate research funds and research contracts for the articulation of educational systems.[3] "There should be every opportunity for qualified individuals to transfer from any type of preparatory program in order to pursue higher education."[4]

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[1]Department of Health, Education, and Welfare, Vocational Education and Occupations, 1970.

[2]Lysaught, Jerome P., Ed. D., An Abstract for Action (New York: McGraw-Hill Publishing Company, 1970), p. 114.

[3]"Summary Report and Recommendations, National Commission for the Study of Nursing and Nursing Education," Nursing Outlook, February, 1970, p. 46.

[4]Ibid.

Minimum levels of knowledge and skill for each level of nursing must be established. Competence must include more than a list of appropriate tasks. At the professional level, it must encompass areas of responsibility which involve judgements and interrelationships of a complex nature.

Many political and legal issues must be resolved in order for the concept of articulation to be implemented. All concerned with the delivery of health care and education of health personnel must work together in order for this most needed transition to occur. Educational resources must be utilized to the fullest extent and prior knowledge and experience recognized in order to make upward mobility possible and prevent duplication.

Materials from Nursing Skills for Allied Health Services, edited by Lucille A. Wood, published by W. B. Saunders Company, 1972, were used in developing "Fundamentals of Nursing." This text is a project produced by a grant from the U. S. Office of Education, Department of Health, Education and Welfare. This material is not under copyright, therefore, written approval to reproduce portions of the text was not necessary. However, permission was requested and a copy of the reply is included in Appendix B, page 93.

RECOMMENDATIONS

Nursing education is unique in many ways, one of which being its consistent emphasis on evaluation of the psychomotor as well as the cognitive and affective domain of learning outcomes. The learner must move from the simple acquisition of knowledge to an ability to administer comprehensive nursing care in an actual situation. Evaluative methods are generally divided into two major areas--written/verbal performance and skill performance with specific criteria established for each.

Teacher-made examinations are utilized to evaluate all materials covered in lecture, group discussion, and all other associated learning activities. While each institution establishes its own grading scale to determine various levels of achievement, it is the recommendation of this team that not less than 75 percent accuracy be required on all student performance unless otherwise specified.

Required written assignments should include nursing care studies, nursing care plans, drug cards, teaching plans, etc. Criteria for this work is established in keeping with the standards established by the institution and the subject matter to which the assignment speaks.

The nursing arts laboratory is utilized primarily for the purpose of providing demonstrations of nursing procedures by the faculty and allowing for return demonstrations by the learner. Criteria are established for each step of each procedure which the learner must master.

The American Nurses' Association has established Standards of Nursing Practice for nursing in general as well as for the specific divisions--Community Health, Geriatrics, Maternal and Child Health, Medical-Surgical, Psychiatric, and Mental Health Nursing Practice. These standards serve as the major criteria for the evaluation of overall performance in the client care setting.

It is the recommendation of this team that Mental Health concepts, Diet Therapy, Pharmacology, and Pediatric Nursing be integrated throughout the curriculum and that advanced Medical-Surgical Nursing of adults and children be taught in two semester courses. While it is the recommendation of this committee that the material be presented in the outlined sequence, final decisions on curriculum will have to be made by each individual institution in keeping with its own philosophy and conceptual framework of education and the requirements of the accrediting agencies.

THE NURSING PROCESS

Unit 1 -- The Scope of Nursing

Terminal Objective:

The learner will demonstrate a basic understanding of the role of nursing in the overall health care delivery system through performance on written tests with no less than 75% accuracy and performance in the clinical area according to established criteria.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Identify, on a teacher-made examination with no less than 75% accuracy, those principles and functions which characterize the nature of nursing as it relates to the nurse and the client.
2. Distinquish, on a teacher-made examination with no less than 75% accuracy, the differences among official, voluntary, and private community agencies or organizations for health care according to their purposes, control, and financial support.
3. Define and document, utilizing three different sources, the concepts of health, illness, clients, and the nursing process in accordance with standards for written work.

Unit 2 - The Client-Nurse Relationship

Terminal Objective:

The learner will establish therapeutic relationships evidenced by acceptable interpersonal reactions and considerations shown to clients and significant others, and convey pertinent aspects of these relationships through appropriate recording on the client's chart.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Identify, through role play in small group settings, good and poor techniques for establishing therapeutic rapport, based on materials presented in assigned learning activities.
2. Identify, in small group settings with no less than 75% accuracy, the type of behavior and type of need represented in visual examples of human behavior at various stages in the life cycle.
3. Identify, on a teacher-made examination, the role assumed by the nurse in each of four clinical situations according to criteria presented in assigned learning activities.

4. Choose the best therapeutic response to client's statements utilizing a teacher-made evaluative tool on communication techniques.
5. Note type and purpose of each component and identify and define prefixes, suffixes, symbols, abbreviations, and medical terms contained in examples of completed charts.
6. Write a complete and accurate description of a client, following a visit with him in the clinical area, utilizing appropriate terminology and scientific principles outlined in handout.

Unit 3 - Health Care Planning

Terminal Objective:

The learner will prepare, according to established criteria, a priority need nursing care plan, utilizing theory knowledge and procedures presented in assigned materials.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Identify and discuss, in small group settings, three major purposes for nursing care planning.
2. Formulate, in small group settings from a written clinical situation, a basic plan of care utilizing the correct steps and sequence of the nursing process as outlined in previously prescribed format.
3. Instruct at least one client, in the clinical setting, regarding one or more aspects of care, utilizing a teaching plan formulated according to established criteria.

Unit 4 - The Health Worker and the Law

Terminal Objective:

The learner will give evidence of her knowledge of the law by answering questions on a written examination, with no less than 75% accuracy, based on definitions of legal terms and an understanding of legal problems which might occur during a client-health worker relationship.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Identify the health worker, with no less than 75% accuracy, in any given situation.
2. Recognize, on a teacher-made examination, the definition for the term "law" as used in this study.
3. List, on a teacher-made examination with no less than 75% accuracy, the main sources for the law and specifically "medical" law.

4. Identify, on a teacher-made examination and/or in the clinical setting with no less than 75% accuracy, the rights of the individual under the law and specifically how these rights might be violated if consent and and medical orders are inadequate.
5. Recognize, in a given situation with no less than 75% accuracy, when an act can be interpreted as malpractice or negligence.
6. Distinquish, on a teacher-made examination with no less than 75% accuracy, civil from criminal law.
7. List, on a teacher-made examination, the responsibilities in relation to legal records based on criteria presented in related learning activities.
8. List, on a teacher-made examination with no less than 75% accuracy, basic rules to follow for the prevention of litigation.

Unit 5 - Introduction to Ethics in the Healing Arts

Terminal Objective:

In a clinical setting the learner will display ethical conduct in the role of the health-related hospital worker. She will answer questions on a teacher-made examination with no less than 75% accuracy, demonstrating an understanding of ethical behavior in health service situations.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:
1. Define ethics, on a teacher-made examination with no less than 75% accuracy.
2. Differentiate, on a teacher-made examination with no less than 75% accuracy, between legal aspects and ethical considerations.
3. Identify, on a teacher-made examination with no less than 75% accuracy, the health team--their functions and limitations.
4. Identify, on a teacher-made examination with no less than 75% accuracy, the necessity for and utilization of ethics in hospital situations.
5. Apply ethical behavior guidelines in judging appropriate choices of action in eight hypothetical health-related situations, with no less than 75% accuracy.

Unit 6 - Environment and the Client

Terminal Objective:

On a written examination, with no less than 75% accuracy, the learner will identify ten environmental factors in a hospital which affect clients' comfort, recovery, and safety.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Define, on a teacher-made examination with no less than 75% accuracy, the terms presented in the vocabulary.
2. Identify, on a teacher-made examination with no less than 75% accuracy, responsibilities of the nurse in environmental management.
3. Identify, on a teacher-made examination with no less than 75% accuracy, the desirable ranges for room temperature and humidity, and acceptable methods of modifying these conditions.
4. Identify, on a teacher-made examination with no less than 75% accuracy, correct methods of providing ventilation.
5. Identify, in a clinical setting with 75% accuracy, ways to control offensive odors.
6. Identify, on a teacher-made examination with no less than 75% accuracy, common noises in the hospital and ways to minimize their effects on clients.
7. List, on a teacher-made examination with no less than 75% accuracy, methods of light adjustment.
8. Identify, on a teacher-made examination with no less than 75% accuracy, methods used to maintain clients' privacy.
9. Identify, on a teacher-made examination with no less than 75% accuracy, safety precautions used in the client's environment.

Unit 7 - Guidelines for Performance of Nursing Skills

Terminal Objective:

On a teacher-made examination, utilizing questions representing client situations, the learner will identify guidelines for performing a nursing skill, with no less than 75% accuracy.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Apply legal and ethical concepts for the safety of the client, worker, and employer when performing nursing tasks in the clinical setting, with no less than 75% accuracy.

2. Communicate with the client, co-workers, and others in such a manner as to make the task safe and effective.
3. Apply, in the clinical setting, the principles of biological and physical science that make the task safe and effective.
4. Prepare to perform the task using the following criteria to evaluate the task:
   A. Condition of the client.
   B. Abilities and limitations of the learner.
   C. Environmental factors that could help or hinder performance.
5. Implement the nursing task utilizing the following guidelines:
   A. Preparing the client physically and mentally.
   B. Preparing the equipment needed.
   C. Performing the task utilizing applicable principles from biological and physical sciences.
   D. Performing follow-up care of the client.
   E. Performing follow-up care of the equipment.
   F. Reporting and/or recording accurately and appropriately.
6. Evaluate the outcome of the task by answering the following questions:
   A. Did the task accomplish the intended purpose?
   B. Was it performed safely?
   C. Was it performed in a manner economical of time, effort, and supplies?

Unit 8 - Body Alignment, Balance, and Movement for Health Workers

Terminal Objective:

The learner will identify and demonstrate good body alignment, balance, and movement by scoring no less than 75% on a performance test and a written test.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Position her body in alignment and balance, and state the reason for the position of her feet, knees, buttocks, and abdomen, thorax, and head, according to the standards outlined in this lesson.
2. Accurately demonstrate in a laboratory setting the body movements of flexion, extension, hyperextension, adduction, and abduction, and describe the movements using terms given in the vocabulary and in the lesson.

3. Answer questions about the following on a written post-test with no less than 75% accuracy:
   A. The vocabulary presented in the lesson.
   B. Principles of good body alignment as presented in this lesson.
   C. Principles of good body balance as presented in this lesson.
   D. Effects of physical forces of gravity.

Unit 9 - Body Alignment, Balance, and Movement for Health Workers (Part 2)

Terminal Objective:

The learner will demonstrate good body alignment, balance, and movement by a performance test and a written test, scoring no less than 75%.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Perform an activity at floor level (e.g., mopping up a spill, or placing slippers on a client's feet), keeping the body aligned and balanced, and using the large muscles of the thighs and buttocks for the activity.
2. Reach and remove a heavy object located at least six inches higher than the learner is tall without hyper-extending, straining the back, or losing her balance.
3. Carry an object weighing 10 to 15 pounds, for five minutes in such a manner as to minimize fatique and prevent straining.
4. Push or pull an object (e.g., wheelchair, laundry cart, food cart), in the clinical setting and/or nursing arts laboratory by "setting" the muscles, using the leg muscles to supply most of the force needed and the body weight to assist the movement.
5. Position the feet and body in such a manner that straining the trunk or back will be prevented when performing an activity that requires turning or pivoting (e.g., assisting a client from bed to chair, or turning from desk to file cabinet.
6. Answer questions on a written post-test, with no less than 75% accuracy, about the following:
   A. The five guidelines that permit good body alignment and efficient movement in the performance of her skills.
   B. The principles of body alignment, balance and movement in reaching for an object, carrying a heavy object, making a pivoting turn, pushing or pulling an object, and in performing an activity at floor level.

Unit 10 - Introduction to Charting

Terminal Objective:

In the clinical setting, the hospital worker or nursing personnel will enter a written account of the health history, therapy given and a client's reaction to therapy on a client's chart. Use of suggested charting terms will provide safe, legally acceptable account of a client's situation.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Record legibly on the client's chart.
2. Properly record on the client's chart information pertaining to the client which will assure safety for the client, hospital, or health worker.
3. Describe on the client's chart the exact time, effect, and reaction of the client to therapy or treatment rendered.
4. Describe on the client's chart the character and amount of drainage, vomitus, stools, urine, or hemorrhage (bleeding) from the body.
5. Describe on the client's chart the type, onset, location, and duration of pain.
6. Note on the client's chart the time, visit, examination, and reaction of the client to the visit of physician or other health workers.
7. Describe on the chart client's condition clearly and concisely.
8. Adapt to the requirements of different health facilities when making entries on the client's chart.
9. Use clear, concise terms which plainly describe a situation pertaining to the client.

Unit 11 - Handwashing Technique for Medical Asepsis

Terminal Objective:

As a means of maintaining standards of cleanliness that will minimize the risk of contracting or transmitting infections, the learner will employ the correct technique for washing the hands at all appropriate times based on criteria established in related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Name the routes by which bacteria can be transmitted, recognize the conditions that are favorable and unfavorable to their growth, and take appropriate handwashing precautions against bacterial contamination in a test situation with no less than 75% accuracy.

2. State on a teacher-made examination, at least five circumstances that necessitate washing the hands, as a result of direct or indirect contact with contaminated materials.
3. Wash the hands without any contamination of hands, body, or clothing in the nursing arts laboratory.
4. Adjust water to the proper warm temperature for washing the hands in the nursing arts laboratory.
5. Apply soap and water in the proper quantities for washing the hands, fingers, wrists, and forearms in the proper sequence.
6. Use the proper rotary and frictional movements to apply firm, even pressure to each area as it is washed.
7. Rinse hands and forearms in the proper manner in a nursing arts laboratory.
8. Clean fingernails and skin folds properly in a nursing arts laboratory.
9. Dry hands carefully, in the clinical setting and nursing arts laboratory, to prevent chapping.
10. Explain and demonstrate to others, in the nursing arts laboratory, the correct handwashing technique.

Unit 12 - Making Hospital Beds

Terminal Objective:

In the clinical setting, the learner will prepare the unoccupied (closed), occupied, and anesthetic hospital bed in a way that presents a neat appearance, remains intact with use, and provides a safe and comfortable environment for the client. The learner will also operate the controls of the bed in order to adjust the position of the bed as may be required.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Adjust, in a nursing arts laboratory, manually operated and electrically operated beds to the positions used during bedmaking and the positions appropriate for completed beds, raising or lowering sections of the bed in the proper sequences, without errors in the selection and operation of the controls.
2. Make an unoccupied bed in a nursing arts laboratory starting from the bare mattress, by selecting the appropriate bed linens that are required, placing these items correctly and securely on the bed, and adjusting the bed in the appropriate position. This must be accomplished in six minutes or less.

3. Make an occupied bed (with a client in it who is able to move without assistance) by selecting the appropriate bed linens. Change all but the top linen, by giving the client the directions for moving, and by adjusting the bed in the proper position for your work.
4. Make an anesthetic or surgical bed by selecting and using the appropriate items of bed linen, with the top bedding pie-folded or fan-folded on one side of the bed to permit easier transfer of a helpless client into the bed, and then adjust the position of the bed appropriately, in six minutes or less.

Unit 13 - Assisting the Client to Dress and Undress

Terminal Objective:

In the clinical setting, the learner will be able to provide partial or total assistance when needed by the client in putting on or removing articles of clothing. The assistance may be needed by a client of any age, ranging from the newborn to the elderly. The learner will provide this assistance regardless of the physical or mental condition of the client without causing him additional discomfort or distress.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:
1. Explain on a teacher-made examination with no less than 75% accuracy, the biological and physical principles concerned with body movement and function that may be used in assisting the client to dress and undress without further injury, discomfort, or distress.
2. Assess the factors in the client's physical condition and ability to cooperate that may interfere with competence to dress or undress and ability or limitations in carrying out the procedures. Note: When needed, secure additional help.
3. Explain to the client, in the clinical setting, the way in which assistance will be given, explaining the various steps of the procedure, enlisting cooperation and assistance when possible.
4. Provide privacy for the client in the removal or putting on of clothing (other than outer garments such as coats, sweaters, boots, shawls, etc.) by using cubicle curtains, screens, closed doors, or nonpublic rooms.
5. Prevent undue exposure of the client's body during the dressing or undressing procedure by using drapes or clothing.
6. Verbally communicate patience, gentleness, and concern for the client and exemplify these nonverbally through behavior and actions.

7. Demonstrate a regard for articles of clothing as the property of others (belonging to client or to hospital) by carefully and neatly storing items not in use, and by not cutting, tearing, and causing damage to clothing.
8. Provide total assistance in removing the soiled gown or pajamas of an adult bed client, and put clean gown or pajamas on the client in five minutes or less.
9. Provide partial assistance in removing the gown or pajamas of a client and assist him to dress in undergarments, street clothing, and shoes in ten minutes or less.

Unit 14 - Baths

Terminal Objective:

The learner will be prepared to meet the client's comfort needs through bathing. These comfort needs include his physical, emotional, and mental well-being.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:
1. Prepare and give, on a performance test in the nursing arts laboratory, a partial bath, cleansing bath, medicated bath, therapeutic bath, and/or sitz bath according to criteria presented in related learning activities.
2. Demonstrate, on a teacher-made examination with no less than 75% accuracy, knowledge of the scientific principles of bathing.

Unit 15 - Care of the Hair

Terminal Objective:

In the clinical setting, the learner will provide partial or total assistance when needed by the client in brushing, combing, arranging and/or shampooing the hair in accordance with criteria presented in related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:
1. Brush, comb, and arrange a client's hair and braid long hair to the satisfaction of the client and in accordance with criteria presented in related learning activities.
2. Prepare a client in bed for a shampoo (or at the sink in the bathroom or utility room), using principles of safety and good body alignment while providing for the client's comfort.
3. Determine when the client's hair is clean by using the "squeaking clean" technique.

4. Improvise a trough effectively to keep the client dry and to provide for water drainage when giving a shampoo in bed or on a stretcher.

Unit 16 - Special Skin Care

Terminal Objective:

The learner will give special care to the geriatric and incontinent client, to the client in a cast or in traction, and to one with an ileostomy or colostomy, while maintaining good body alignment for the client and the worker. This procedure should provide a safe, comfortable environment for the client.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Prevent decubitus ulcers by correct examination of the client's skin, and removal of pressure from bony prominences (such as the sacrum or heels) by correctly changing the client's position and using appropriate supportive aids.
2. Identify, in the clinical setting, specific skin reactions such as cyanosis, increased redness, or broken skin which are indicative of impending decubitus ulcers and initiate appropriate nursing measures to arrest the formations.
3. Detect signs of impaired circulation of an extremity in a client with a cast, and start appropriate nursing measures to prevent further impairment, according to criteria presented in related learning activities.
4. Change an ileostomy or colostomy prosthesis using the proper technique, observing the skin condition, applying the appropriate ointment and prosthesis, and providing understanding and reassurance to the client, according to criteria presented in related learning activities.
5. Clean and cut a client's toenails or fingernails according to agency procedure.

Unit 17 - Client Movement and Ambulation

Terminal Objective:

In the clinical setting, the learner will assist the client (or another person) to move his various joints through the range-of-motion exercises, to dangle his feet at the side of the bed, to stand, and to walk in a safe manner without causing additional pain or injury.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Assess the client's physical and mental condition that may interfere with his ability to exercise his joints or to ambulate, as well as the ability or limitations to carry out the procedures. Note: When needed, the learner will secure additional help.
2. Verbally communicate patience, gentleness, and concern for the client, and express them nonverbally through behavior and actions.
3. Explain to a client (with limited or no motion in the joints, on one side of his body) the need for exercising all of the joints; show him how to exercise the joints on his unaffected side, and carry out the range-of-motion exercises for the affected joints. In performing the range-of-motion exercises, the learner will:
   A. Provide support for the body part that is away from the joint being exercised.
   B. Avoid forcing movement in the joint to the point that it causes pain.
4. Assist the client in bed to dangle his feet over the side of the bed by positioning him on the proximal side of the bed, bringing him to a sitting position, pivoting his body, and swinging his feet over the side of the bed in smooth, flowing motions, using principles of good body alignment and movement.
5. Assist the client to stand, to balance, and to walk safely, using principles of good body alignment and movement.
6. Assist the client (whether a youth or an adult) who has lost his balance and begun to fall by grasping him firmly, slowing the rate of descent, and easing him slowly to the floor or ground in order to avoid injury to the client or to the health worker, by utilizing the principles related to gravity.

Unit 18 - Mechanical Aids for Ambulation and Movement

Terminal Objective:

In the clinical setting, the learner will assist the client (or another person) to use common mechanical aids for ambulation or movement in a safe and effective manner, according to criteria established in related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Assess any physical or mental condition which may interfere with the client's ability to use mechanical aids in his ambulation or movement; assess existing limitations in carrying out the required procedure and obtain additional help if needed.

2. Communicate patience, gentleness, and concern for the client verbally as well as nonverbally through behavior and actions.
3. Assist the client who is able to stand to transfer from the bed to wheelchair then reverse the procedure in transferring from wheelchair back to bed.
4. Transfer, with assistance, a client who is unable to stand, from the bed to a wheelchair by positioning the chair, setting the brakes, positioning the client, lifting on signal, placing the client in the wheelchair, and adjusting the leg or foot rests. The principles of good body alignment, balance, and lifting must be used.
5. Instruct a client in the use of a wheelchair when it is to be used by him as a method of locomotion.
6. Assist a client in bed to transfer into and out of a walker to the height best suited to his use.
7. Measure and adjust a pair of crutches to the proper length needed by the client, and adjust the hand-bar.
8. Demonstrate to a client two-point, three-point, and four-point crutch-walking, and explain the conditions related to each based on material presented in related learning activities.
9. Explain, on a teacher-made examination with no less than 75% accuracy, the principles of crutch-walking and the cause of "crutch palsy."
10. Apply a strap-on type of back brace, and explain to the client how to check for proper fit and for possible pressure areas, according to criteria presented in related learning activities.
11. Apply a short leg brace, and explain to the client how to check for proper fit and for possible pressure areas based on material presented in related learning activities.

Unit 19 - Positioning the Bed Client

Terminal Objective:

In the clinical setting, the learner will position the bed client in good body alignment for his health and comfort, using various aids for support or immobilization of various body parts, as well as protective aids to reduce pressure on skin areas.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Provide, in a nursing arts laboratory, support for or immobilization of various parts of the body with the use of aids such as pillows, footboards, sandbags, sand rolls, and trochanter rolls, according to criteria presented in related learning activities.

2. Reduce and prevent formation of pressure areas through the use of protective aids such as pillows, synthetic lamb's wool pads (Decubinex), foam-rubber pads, overbed cradle, protective heel (Posey), or flotation as with the alternating air-pressure mattress pad.
3. Place the helpless bed client in the basic supine position according to the principles of positioning, and in the variations of this position which include Fowler's, semi-Fowler's, and Trendelenburg's.
4. Place the helpless bed client in the basic lateral position according to the principles of positioning, and in the Sims variation of this position.
5. Place the helpless bed client in the basic prone position according to the principles of positioning.
6. Move the bed client toward the head of the bed by using good body movements to prevent strain or injury to the client or health worker.

Unit 20 - Assisting with Nutrition

Terminal Objective:

On a teacher-made examination, with no less than 75% accuracy, the learner will demonstrate knowledge of basic foods and general nutrition for adults and children. In the clinical setting, the learner will assist the adult and the child with nutrition, and make a record of oral intake and output, according to criteria presented in related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:
1. Assist or feed an adult client and a pediatric client with solids and liquids, according to criteria presented in related learning activities.
3. Serve and collect meal trays and nourishments in the clinical setting, according to criteria presented in related learning activities.

Unit 21 - Fluid Intake and Output (I and O)

Terminal Objective:

In the clinical setting, the learner will accurately measure oral fluid intake and fluid output, and maintain records as required for determination of fluid balance, according to criteria presented in related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Identify, on a teacher-made examination and/or in the clinical setting with no less than 75% accuracy, all food items that should be measured as fluid intake.
2. Convert, on a teacher-made examination with no less than 75% accuracy, volumetric measurements from English and household units to metric units.
3. Measure, in the nursing arts laboratory with no less than 75% accuracy, fluid volume with a graduated container.
4. Give instructions, appropriate to the condition and sex of a client, for voiding in a manner that will permit measurement.
5. Keep accurate quantitative records of oral fluid intake and fluid output and make determinations of total I and O as required by physician's orders.
6. Record qualitative observations on fluid output, according to criteria presented in related learning activities.
7. Recognize, note, and report symptoms of edema and dehydration, and conditions of unusual or excessive fluid output, according to criteria presented in related learning activities.
8. Define, on a teacher-made examination with no less than 75% accuracy, frequently used terms that refer to mechanisms and conditions of fluid balance.

Unit 22 - Observing Intravenous Therapy

Terminal Objective:

In the clinical setting, the learner will give daily care to a client who is receiving IV therapy, applying appropriate safety measures throughout the procedure.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Give daily care (bath, dress/undress, meals, etc.) to a client with an IV, according to criteria presented in related learning activities.
2. Assist a client to ambulate with an IV, according to criteria presented in related learning activities.
3. Recognize the need for professional assistance while caring for a client receiving IV therapy and call for assistance as needed.
4. Practice proper safety precautions for the client receiving IV therapy, according to criteria presented in related learning activities.

Unit 23 - Assisting with Spiritual Care

Terminal Objective:

In the clinical setting, the learner will assist the client to obtain the services of the clergyman for his spiritual needs, provide for the observance of certain religious practices, and assist the clergyman as may be needed. The learner will show respect for the client's religious beliefs even though these may differ from her own.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Call the religious representative requested or designated by the client, according to the policies of the institution.
2. Assist the client to observe certain religious practices during his stay in the hospital, if he so wishes.
3. Show concern for the religious articles belonging to the client by handling them respectfully and providing for their safekeeping.
4. Demonstrate respect for the client's religious beliefs in all aspects of conduct.

Unit 24 - Urine Elimination

Terminal Objective:

In the clinical setting, the learner will demonstrate ability to assist the client to use the designated equipment to void in a safe and effective manner; to collect specific urine specimens; and to test urine for sugar and acetone content, using the prescribed procedure.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Assist the client to safely and modestly use the equipment to void so that the urine can be measured with 100% accuracy.
2. Obtain a specified urine specimen (routine, clean catch, timed), correctly label and provide for immediate transfer of specimen to the laboratory for analysis, and record appropriate information on the client's chart, according to criteria presented in related learning activities.
3. Record significant observations about the urinary output of the client: amount, color, odor, and time.
4. Enter accurate intake and output measurements on the Intake and Output Record, according to criteria presented in related learning activities.

5. Remove, clean, dry, and return to storage the designated equipment used in urinary elimination and the testing of diabetic urine.
6. Provide opportunity for the client to wash and dry hands following elimination, according to criteria presented in related learning activities.
7. Obtain and test specimen of diabetic urine for sugar and acetone, and record appropriate information on the client's record, according to criteria presented in related learning activities.

Unit 25 - Bowel Elimination

Terminal Objective:

In the clinical setting, the learner will assist the client in establishing and maintaining regular elimination of waste products from the large intestine using methods appropriate to the client's age, physical condition, and disease.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Identify, on a teacher-made examination with no less than 75% accuracy, some of the abnormal conditions manifested in the appearance of the client's stool, such as the presence of blood, mucus, iron, worms or other parasites.
2. Collect a stool specimen and prepare it for examination in the laboratory, according to the policies of the institution.
3. Promote the client's regular elimination of waste products from the large bowel through nursing measures related to the prescribed diet, fluid intake, exercise, and rest.
4. Reduce incontinence of feces in clients of any age through methods of habit training and retraining, according to procedures presented in related learning activities.
5. Assist evacuation of feces and flatus in the hypoactive bowel through the use of the enema, rectal tube, or Harris flush, according to criteria presented in related learning activities.
6. Examine the client for the presence of constipated stool in the rectum and promote its evacuation by the use of suppositories, cleaning or retention enemas, according to criteria presented in related learning activities.
7. Assist and teach the client with a colostomy or ileostomy to irrigate his bowel to cleanse it of fecal material, to prevent obstruction, and to establish a habit of regular evacuation, according to criteria presented in related learning activities.

Unit 26 - Collection of Sputum and Gastric Specimens and Care of the Vomiting Client

Terminal Objective:

In the clinical setting, the learner will assist the client to provide a sample of sputum and to collect and label sputum and gastric content specimens for the laboratory.

The learner will also take care of the vomiting client in a skillful and effective manner while giving him emotional reassurance and physical support.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Instruct and assist the client to produce sputum without undue discomfort and distress, and collect the sputum specimen for delivery to the laboratory, according to the policies of the institution.
2. Collect a gastric content specimen and prepare it for delivery to the laboratory, according to the policies of the institution.
3. Provide care for the client who is or has been vomiting, in such a manner that he will feel more comfortable, and thereby reduce the stimulation of the "gagging" or vomiting reflex.

Unit 27 - Perineal Care

Terminal Objective:

In the clinical setting, the learner will assist the client with the care and cleanliness of his perineal area, and give perineal care as required in a skillful, effective, and reassuring manner in order to reduce or avoid embarrassment to the client.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Provide perineal care for the female client by pouring warm solution over the perineal area, cleansing and drying the area properly, applying a dressing or pad, if required, and securing it in place.
2. Provide perineal care for the male client by pouring warm solution over the perineal area, cleansing and drying the area properly, applying a pad or dressing, if required, and securing the dressing in place.
3. Approach the client, explain the procedure of perineal care in an objective or matter-of-fact way, and give reassurance in a nonjudgmental way in order to avoid embarrassing the client.

Unit 28 - Care of the Client with Gastrointestinal Tubes

Terminal Objective:

In the clinical setting, the learner will employ the correct techniques for caring for clients with various gastrointestinal tubes: Tubes with suction, without suction, and those used for special feedings and special laboratory tests, according to criteria presented in related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Identify, on a teacher-made examination with no less than 75% accuracy, four kinds of tubes used in the gastric analysis procedure.
2. Assemble equipment and assist with the insertion of the various gastrointestinal tubes, according to criteria established in related learning activities.
3. Feed a client with a gastrostomy or enterostomy tube, or through the proctoclysis procedure, according to criteria presented in related learning activities.
4. Identify and describe, on a teacher-made examination with no less than 75% accuracy, the action of the four common types of suction apparatus, e.g., portable electric suction, wall-outlet suction, Gomco Thermotic Pump, and a water displacement system, with or without suction and with intermittent or continuous action.
5. Describe and be prepared to give major nursing care activities to clients with various types of gastrointestinal tubes, e.g., testing, drainage, suction, and feeding, according to criteria established in related learning activities.
6. Describe and record correctly and accurately the color, amount, and consistency of the intake and/or output of clients with gastrointestinal tubes discussed in this unit.

Unit 29 - The Cardinal Signs: Temperature, Pulse, Respiration, and Blood Pressure

Terminal Objective:

In the clinical setting, the learner will obtain accurate temperature, pulse, respiration, and blood pressure readings on adults and children, and record these readings correctly on the client's chart, according to criteria presented in related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Take and record the body temperature of an adult and a child by use of a glass or electric thermometer orally, rectally, or axillary, according to criteria established in related learning activities.

2. Take and record an apical and radial pulse of an adult client, according to criteria presented in related learning activities.
3. Count and record the client's respiration, according to criteria presented in related learning activities.
4. Take and record the client's blood pressure, according to criteria presented in related learning activities.
5. Recognize, on a teacher-made examination and/or in the clinical setting with no less than 75% accuracy, deviations from normal vital sign patterns.

Unit 30 - Admission, Transfer, and Discharge

Terminal Objective:

In the clinical setting, the learner will admit, transfer, or discharge a client correctly while demonstrating concern for his physical and emotional well-being as well as for his personal belongings.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:
1. Take and record observations of the client's physical and emotional condition at the time of admission, according to criteria presented in related learning activities.
2. Explain to the client about the hospital environment and routine (including the operation of the electric bed controls, the TV controls, and the nurse-call communication system).
3. Take safe care of the client's personal belongings during his stay in the agency or during transfer to another location, according to the policies of the institution.
4. Prepare the client and his belongings for discharge, according to criteria established in related learning activities and the policies of the institution.
5. Complete the necessary admission, transfer, and discharge forms, according to the policies of the institution.

Unit 31 - Care of the Dying Client and Postmortem Care

Terminal Objective:

In the clinical setting, the learner will prepare a body after death, including the care of skin, body orifices, tubings, and valuables.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:
1. Name and describe, on a teacher-made examination with no less than 75% accuracy, the five stages of dying.

2. Demonstrate concern and respect for the client's body by moving it gently and carefully and without injury.
3. Protect the client's valuables, no matter how small and seemingly insignificant, according to the policies of the institution.
4. Demonstrate, in the clinical setting following the death of a client, the correct care of drainage tubes, according to criteria established in related learning activities and the policies of the institution.

Unit 32 - Care of Clients Receiving Oxygen Therapy

Terminal Objective:

In the clinical setting, the learner will administer the various oxygen therapies as well as the nursing care for client's receiving oxygen therapy based on criteria established in related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:
1. Describe and identify, on a teacher-made examination with no less than 75% accuracy, the methods of oxygen therapy administered to clients.
2. Demonstrate, in the clinical setting, how to regulate oxygen flow and how to care for a client with an oxygen tent, nasal cannula, nasal catheter, oxygen mask, or IPPB (intermittent positive pressure breathing apparatus). and properly record the activities, according to criteria presented in related learning activities.
3. Demonstrate and discuss, in the clinical setting, safety precautions which must be observed when clients are receiving oxygen therapies, according to criteria presented in related learning activities.

Unit 33 - Cardiopulmonary Resuscitation

Terminal Objective:

In the clinical setting, the learner will recognize the symptoms of cardiac arrest and institute emergency cardiopulmonary resuscitation technique as presented in related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:
1. Describe, on a teacher-made examination with no less than 75% accuracy, the signs and symptoms of cardiac standstill (cardiac arrest).
2. Provide a patent airway for a client requiring cardiopulmonary resuscitation, according to criteria presented in related learning activities.

3. Initiate mouth-to-mouth resuscitation to clients, according to criteria presented in related learning activities.
4. Initiate closed-chest massage to clients, according to criteria presented in related learning activities.

(Steps 3 and 4 will be done only if the agency permits the learner to initiate these procedures. However, everyone should know how to do them in order to assist the nurse or doctor as needed throughout the procedure.)

Unit 34 - Assisting with Procedures

Terminal Objective:

In the clinical setting, the learner will apply heat and cold as treatments for the client's condition accurately, effectively, and safely, according to criteria established in related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:
1. Apply heat locally to a portion of the client's body using a hot water bottle, a heating pad, a heat cradle, or aquathermia pad, according to criteria presented in related learning activities.
2. Apply cold locally to a portion of the client's body, using an ice cap, ice pack, or a hypothermia machine, according to criteria presented in related learning activities.
3. Assist in setting up and operating the hypothermia/hyperthermia machine for the general application of heat or cold to the body correctly, efficiently, and safely, according to criteria presented in related learning activities.

Unit 35 - Application of Bandages and Binders

Terminal Objective:

In the clinical setting, the learner will apply clean bandages and binders, according to criteria established in related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:
1. Apply, in a nursing arts laboratory, figure 8, spiral, spiral reverse, and recurrent bandages, according to criteria established in related learning activities.

2. Apply, in a nursing arts laboratory, scultetus, straight abdominal, T-binder, double-T binder, breast binders, and an Ace bandage, according to criteria presented in related learning activities.
3. List, on a teacher-made examination with no less than 75% accuracy, the reasons for which bandages and binders are applied.
4. In the clinical setting, check the client for impaired circulation in an area which is wrapped with a binder or a bandage and take steps to remove the impairment as soon as discovered, according to criteria presented in related learning activities.

Unit 36 - Pre-operative Care of a Client

Terminal Objective:

In the clinical setting, the learner will prepare a client for a surgical operation, according to criteria established in related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Provide the client with privacy and safety during the pre-operative preparations.
2. Procure a surgical consent from the client, if agency policy permits the nurse to perform this duty.
3. Explain to the client the reasons for pre-operative laboratory procedures, according to criteria established in related learning activities.
4. Safeguard the client from any food or fluids in the specified period prior to surgery.
5. Provide the necessary personal hygiene as required during pre-operative preparation, according to criteria presented in related learning activities.
6. Eliminate safety hazards to the client after he receives the pre-operative medications.
7. Instruct the client and family regarding the recovery and waiting rooms.
8. Complete a pre-operative checklist accurately.

Unit 37 - Preparation of Consents, Releases, and Incidents

Terminal Objective:

In the clinical setting, the learner will obtain consents and releases and complete Incident Reports according to legal requirements.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Recognize, on a teacher-made examination with no less than 75% accuracy, the circumstances and procedures which require consents or releases and prepare appropriate reports.
2. Explain the purpose and meaning of consents and releases to clients and other persons and obtain a legally valid consent or release from a client or guardian.
3. Recognize an incident in the clinical setting, and report the incident in the proper manner, according to the policy of the institution and criteria presented in related learning activities.

Unit 38 - Post-Operative Care of a Client

Terminal Objective:

In the clinical setting, the learner will assemble the required equipment and provide post-operative care to the unconscious or helpless client recovering from anesthesia, or the one who has fully recovered from anesthesia in such a manner as to protect the client's safety by the early detection and prevention (when possible) of post-operative discomforts and complications, and to promote his recovery and rehabilitation.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Maintain open breathing for the unconscious or helpless client through the use of an artificial airway, proper positioning of the client, and suctioning of secretions from the mouth and throat.
2. Observe for signs of shock or hemorrhage by taking and recording the vital signs every 15 minutes during the period immediately after surgery, by frequent inspection of the dressings for signs of unusual bleeding, and by checking any drainage or vomitus for the presence of blood.
3. Insure the safety of the client by the use of siderails on the bed to prevent falling, by not leaving the unconscious or anesthetized client alone, and by setting up the post-op room completely and correctly.
4. Accurately record the intake and output from all sources as indicators of the client's fluid and electrolyte balance, connect all tubes to suction or drainage as appropriate, and use care to keep the IV running in the vein.

5. Provide for the client's comfort and relief of pain through careful handling, with frequent turning or change of position, avoiding unnecessary noise or confusion, and anchoring the drainage tubes. If pain persists, notify the team leader or the nurse in charge without delay.
6. Prevent respiratory complications by changing the client's position at least every two hours, instructing him to breathe deeply and to cough, and supporting the operative site during coughing.
7. Observe and maintain an adequate urinary output by encouraging intake of sufficient fluids, checking for signs of urinary retention, and promoting the elimination of urine by encouraging voluntary voiding or the use of a catheter when ordered by the physician.
8. Reduce or relieve the discomforts related to the client's gastrointestinal tract (i.e., nausea, vomiting, gas pains, and constipation) through appropriate medical and nursing measures.
9. Provide for the personal hygiene needs of the client during the anesthesia recovery period by changing his gown and bed linen as needed, bathing his face and body of perspiration or secretions, and assisting with personal hygiene, usually for several days, giving particular attention to oral hygiene.
10. Provide passive exercise of the unconscious or helpless client's arms and legs at least twice a day, encourage active exercise by the alert client, and promote the goal of early ambulation.

Unit 39 - Isolation Technique

Terminal Objective:

The learner will correctly employ isolation technique to protect herself and others when caring for a client in an isolation unit. She will be able to use reverse isolation technique to protect the client who is suffering from a denuded skin area (e.g., after a burn) or a weakened condition such as leukemia or post-organ transplant, from infecting himself. The learner will employ the principles and practices of terminally disinfecting a unit occupied by a client who has a communicable disease.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:
1. Prepare, in a clinical setting, a unit for isolation of a client who has a communicable disease or who needs protection from infection, according to criteria established in related learning activities.
2. Put on and remove a gown worn in an isolation unit utilizing proper technique.

3. Put on a mask, in the nursing arts laboratory, and tell the instructor how to change it to retain safe isolation technique practice.
4. Put on and remove rubber gloves, in a nursing arts laboratory, utilizing proper technique.
5. Care for contaminated dishes, linen, and dispose of the wastes of clients in an isolation unit.
6. Collect specimens of client in an isolation unit and transfer them to designated places utilizing proper precautions.

Unit 40 - Application of Hot and Cold Compresses, Packs and Soaks (non-sterile)

Terminal Objective:

In the clinical setting, the learner will prepare and administer non-sterile moist hot and cold compresses, packs and soaks, according to criteria established in related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:
1. Assemble, in a clinical setting and/or nursing arts laboratory, supplies and equipment necessary to correctly administer moist hot and cold compresses, packs and soaks.
2. Apply the various moist hot and cold applications, in the clinical setting and a nursing arts laboratory, using safety precautions to prevent injury to the client and to the health worker.
3. Discuss, on a teacher-made examination with no less than 75% accuracy, the purpose and objectives for the local application of heat and cold.
4. Discuss, on a teacher-made examination with no less than 75% accuracy, the various physiological effects of moist heat and cold treatments.

Unit 41 - Standard First Aid American National Red Cross

Terminal Objective:

The learner will recognize sudden illness requiring first aid and perform the skill recommended in the course with no less than 75% accuracy.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will complete the written test and perform the following skills:
1. Employ first aid for wounds--direct pressure, elevation, and pressure points.

2. Apply and remove a tourniquet.
3. Administer artificial respiration.
4. Apply bandaging--closed spiral, open spiral, cravat, triangular head bandage, and arm sling.
5. Immobilize an extremity by splinting--upper arm, forearm, ankle, kneecap, open fracture of leg.
6. Perform rescue and transfer activities--drag by shoulders, blanket drag, two-man carry, carry by extremities, improvised litter carry, three-man hammock carry, litter carry and traction blanket lift.

EXIT NURSE AIDE

Unit 42 - Surgical Aseptic Technique

Terminal Objective:

In the clinical setting, the learner will correctly employ surgical aseptic technique to protect herself, the client, and others from contamination and infection.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Perform, in the clinical setting, a surgical or obstetric scrub, according to criteria presented in related learning activities.
2. Put on a sterile gown and gloves, in the clinical setting or nursing arts laboratory, utilizing aseptic technique.
3. Change sterile dressings and apply sterile hot or cold applications, in the clinical setting and/or nursing arts laboratory, utilizing aseptic technique.
4. Pour sterile solutions and handle sterile instruments, in the clinical setting and/or nursing arts laboratory, utilizing aseptic technique.
5. Open sterile packages, in the clinical setting and/or nursing arts laboratory, without contaminating the contents.
6. Discuss, on a teacher-made examination with no less than 75% accuracy, four of the six broad classes of microorganisms, and be able to identify at least two common diseases which are caused by these organisms.
7. Discuss, on a teacher-made examination with no less than 75% accuracy, at least four principles for maintaining surgical aseptic technique.

Unit 43 - Preparation and Administration of Medications

Terminal Objective:

In the clinical setting, the learner will prepare and give medications to the client accurately, efficiently and safely, according criteria established in related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Prepare and give oral medications to the client in an accurate, efficient, and safe manner that will not cause apprehension or injury to the client.
2. Prepare and give subcutaneous, intramuscular, and intradermal injection medications to the client in an accurate, efficient, and safe manner that will not cause apprehension or injury to the client.
3. Assist with the administration of intravenous medications in an accurate, efficient, and safe manner that will not cause apprehension or injury to the client.
4. Prepare and place inhalation medications in the inhalation equipment in an accurate, efficient, and safe manner that will not cause apprehension or injury to the client.
5. Apply topical medications to the client in an accurate, efficient, and safe manner that will not cause apprehension or injury to the client.
6. Prepare and give rectal or vaginal medications to the client in an accurate, efficient, and safe manner that will not cause apprehension or injury to the client.

Unit 44 - Preparing for and Assisting with Examinations

Terminal Objective:

In the clinical setting, according to criteria established in related learning activities, the learner will assemble the equipment to be used for the specified type of physical examination, prepare the client (which includes correct positioning and draping), and assist both the client and the physician during the examination.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit, the learner will:

1. Assemble all the supplies and equipment required by the physician for a general physical examination of a client, including everything needed for a rectal and vaginal examination when required.
2. Prepare the client for the examination by providing instructions which he can understand, position him to facilitate the examination, and drape him to avoid unnecessary exposure or embarrassment.
3. Assist the physician in the physical examination by taking certain physiological measurements, supplying items as requested, and carrying out other tasks which may be required.

4. Assemble the supplies and equipment required by the physician for the examination of specific areas of the body, prepare the client for the examination, and assist the physician and the client as needed during the actual examination. These specialized examinations utilize clean, nonsterile technique and include proctoscopy, sigmoidoscopy, gastroscopy, neurological examination, and those procedures related to ear, eye, nose, and throat.

Unit 45 Irrigations and Instillations

Terminal Objective:

In the clinical setting, the learner will correctly irrigate and instill medications into a body part or cavity, according to criteria established in related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Demonstrate, on a teacher-made examination with no less than 75% accuracy, general understanding of the body part to be irrigated or into which a medication is to be instilled.
2. Carry out, in a clinical setting, the procedure of irrigation and/or instillation of the body part with proper technique (bladder, kidney, ear, eye, nose, throat, vagina, wound).
3. Discuss, on a teacher-made examination with no less than 75% accuracy, the ramifications of microbiology, physiology pharmacology, and psychosocial aspects associated with the procedure and with the body part to be irrigated.

Unit 46 - Urinary Catheterization

Terminal Objective:

In the clinical setting, catheterize a client, obtain a sterile urine specimen, and insert a retention catheter, according to criteria established in related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Describe, on a teacher-made examination with no less than 75% accuracy, the indications for the insertion of a retention catheter.
2. Catheterize a client and/or a simulated model using aseptic technique, according to criteria presented in related learning activities.
3. Distinquish, on a teacher-made examination with no less than 75% accuracy, between retention and suppression of urine and explain difference.

4. Identify, on a teacher-made examination with no less than 75% accuracy, common urinary catheters (e.g., French, Foley), and describe their uses.

Unit 47 - Pharyngeal Suctioning

Terminal Objective:

In the clinical setting, the learner will safely and correctly suction the nose, throat, and trachea of a conscious and/or unconscious client, according to criteria established in related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Suction the nasal passageway, throat, and pharynx of clients, in the clinical unit, according to criteria presented in related learning activities.
2. Provide personal hygiene as required for the client.
3. Provide safety measures for the client while carrying out the suctioning procedure.
4. Instruct the client and the family regarding suctioning.
5. Provide a patent airway for the client.
6. Describe, on a teacher-made examination with no less than 75% accuracy, the indications for nasal or pharyngeal suctioning.

Unit 48 - Tracheostomy Care

Terminal Objective:

In the clinical setting, the learner will administer comprehensive care to a client who has a tracheostomy tube, according to criteria established in related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Identify, on a teacher-made examination with no less than 75% accuracy, the different types of tracheostomy tubes and their component parts.
2. Provide, in a clinical setting, a patent airway for the client with a tracheostomy, according to criteria presented in related learning activities.
3. Recognize, in the clinical setting, the indications for a tracheostomy.
4. Provide the special personal hygiene required for the client with a tracheostomy, as presented in related learning activities.
5. Eliminate, in the clinical setting, hazards to the client who has a tracheostomy tube inserted.

6. Suction the tracheo-bronchial tree without injury to the client and without dislodging the tracheostomy tube, in accordance with criteria presented in related learning activities and the procedures recommended by the individual institution.

Unit 49 - Application of Tourniquets

Terminal Objective:

In the clinical setting, the learner will apply tourniquets for the treatment of pulmonary edema, and for the Trendelenburg and Perthes circulatory tests, according to criteria established in related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Describe, on a teacher-made examination with no less than 75% accuracy, the indications for the use of tourniquets in the treatment of pulmonary edema and diagnosis of circulatory disturbances.
2. Discuss with the instructor, on an individual basis, the main objectives of therapy for pulmonary edema and the diagnostic circulatory tests (Perthes and Trendelenburg) presented in assigned learning activities.
3. Describe and employ the safety precautions presented in related learning activities when using the various tourniquets both in the nursing arts laboratory and in the clinical setting.
4. Instruct the client regarding the reasons for applying the tourniquets.
5. Apply the rotating tourniquet, according to criteria presented in related learning activities.
6. Apply the tourniquets for the Trendelenburg and Perthes circulatory tests, in the nursing arts laboratory and in the clinical setting, according to criteria presented in related learning activities.

Unit 50 - Insertion of Nasogastric and Gavage Tubes

Terminal Objective:

In the clinical setting, the learner will employ the correct techniques for inserting gastrointestinal tubes, tubes used for special feedings, and special laboratory tests, according to criteria established in related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Assemble equipment and insert the various kinds of gastrointestinal tubes, according to established criteria, without causing injury to the client.
2. Feed a client via a nasogastric, a gastrostomy, or an enterostomy tube, in accordance with established criteria for performing the procedure and the physician's orders regarding the feeding.
3. List, on a teacher-made examination with no less than 75% accuracy, precautions to observe upon insertion and feeding with nasogastric tubes.

Unit 51 - Smears and Cultures

Terminal Objective:

In the clinical setting, the learner will demonstrate the procedure for obtaining a smear or culture using medical or surgical aseptic technique as required.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Take a smear (vaginal, cervical, urethral and/or rectal), according to criteria established in related learning activities.
2. Take a throat or wound culture, according to criteria presented in related learning activities.

Unit 52 - Skin Tests, Immunizations, and other Prophylactic Agents

Terminal Objective:

In the clinical setting, the learner will administer a skin test to a client and accurately read the reaction, according to criteria established in related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Apply a patch test to a client, according to criteria presented in related learning activities.
2. Perform a scratch test on a client and read the results, according to criteria presented in related learning activities.
3. Perform a tuberculin test and interpret the results, according to criteria presented in related learning activities.

Unit 53 - Assisting with Somatic Psychiatric Therapies

Terminal Objective:

In the clinical setting, the learner will safely and correctly assist the physician in giving electroconvulsive shock and insulin coma treatments to clients.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Assemble supplies and have the electroconvulsive therapy (ECT) equipment in working order to prepare for giving ECT treatment.
2. Prepare the client physically and mentally for the ECT or insulin coma treatment, according to criteria presented in related learning activities.
3. Prepare the client for placement of the electrodes and test the electrodes for conduction.
4. Insert the mouth gag prior to beginning the ECT treatment without injuring the client.
5. Observe and record the client's vital signs and levels of consciousness following the somatic treatment.
6. Discuss, on a teacher-made examination with no less than 75% accuracy, the two methods for terminating the insulin coma treatment.

Unit 54 - Techniques of Fetal and Maternal Monitoring

Terminal Objective:

In the clinical setting, the learner will place external transducers so that accurate uterine activity and fetal heart rates can be obtained. The health worker will also assist with the insertion of an intrauterine catheter, clip electrode and/or spiral electrode, as well as the collection of a fetal blood sample.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Apply the tocodynamometer to a client in labor so that an accurate recording of uterine activity may be obtained.
2. Apply an ultrasonic transducer to a client in labor so that an accurate fetal heart rate (FHR) can be obtained and explain, on a teacher-made examination and/or in the clinical setting with no less than 75% accuracy, the advantages and disadvantages of the indirect monitoring technique.

3. Assist with the application of an intrauterine catheter while maintaining an aseptic field, providing emotional support for the mother, and assuring that she is properly grounded to prevent the possibility of an electrical burn on the skin.
4. Explain, on a teacher-made examination with no less than 75% accuracy, the advantages and disadvantages of the direct monitoring technique.
5 Assist with the application or removal of a clip or spiral electrode while maintaining an aseptic field, providing emotional support to the mother, and assuring that she is properly grounded to prevent the possibility of an electrical burn.
6. Assist with the collection of a fetal blood sample, according to criteria presented in related learning activities.

MEDICAL-SURGICAL NURSING

Unit 55 - Classification and Cause of Disease

Terminal Objective:

Given a teacher-made examination, the learner will differentiate, with no less than 75% accuracy, the major recognized causes of disease.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:
1. Select, research, and discuss in small groups, major recognized causes of disease, relating definition, etiological factors, major signs and symptoms, and prognosis.
2. Answer, on a teacher-made examination with no less than 75% accuracy, objective questions from information obtained in group discussion.

Unit 56 - Communicable Disease Nursing

Terminal Objective:

In the hospital or community setting, the learner will administer comprehensive nursing care to clients with the more common communicable diseases, according to established criteria.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:
1. Demonstrate, in the clinical setting, the specific barrier technique necessitated by the mode of transmission of the causative organism of not less than five communicable diseases.

2. Discuss, on a teacher-made examination with no less than 75% accuracy, the four types of immunity.
3. Answer questions, on a teacher-made examination with no less than 75% accuracy, regarding scheduling of standard immunizations currently recommended for a person from infancy through adulthood.
4. Answer questions, on a teacher-made examination with no less than 75% accuracy, regarding comprehensive care of clients with communicable diseases.

Unit 57 - Caring for the Client with Fluid and Electrolyte Disturbances

Terminal Objective:

Given a clinical situation of fluid, electrolyte, and/or acid-base imbalance, the learner will develop and implement a nursing care plan based on accurate assessment, knowledge of specific treatments available and awareness of associated complications.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:
1. Answer questions, on a teacher-made examination with no less than 75% accuracy, regarding the nature of fluids, electrolytes, and acid-base imbalance.
2. Identify, on a teacher-made examination and/or in the clinical setting with no less than 75% accuracy, the major signs and symptoms of fluid, electrolyte, and acid-base imbalance.
3. Distinguish between metabolic and respiratory acidosis or alkalosis on a teacher-made examination and/or on a nursing care plan, with no less than 75% accuracy.

Unit 58 - Caring for the Client Requiring Surgical Intervention

Terminal Objective:

The learner will employ appropriate nursing measures in physical and psychosocial and spiritual preparation and care of the client requiring surgical intervention based on presented criteria.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:
1. Answer objective questions, on a teacher-made examination with no less than 75% accuracy, regarding all phases of the care of a surgical client as presented in assigned learning activities.

2. Observe and/or perform the functions of the surgical nurse in the clinical laboratory and/or operating room setting, under direct supervision.
3. Administer comprehensive nursing care to clients who are recovering from the effects of anethesia, under direct supervision and according to standards defined in assigned learning activities.
4. Prepare a drug card for each medication listed stating action, route of administration, usual dosage and untoward effects. Answer study questions contained in a learning activities package relating to clients requiring surgical intervention with no less than 95% accuracy. A score of no less than 75% will be acceptable on post-test to be completed by the learner.
5. Administer comprehensive care to the client during the continuing post-operative period, according to specified criteria.
6. Match from a list of diets and foods, with no less than 75% accuracy, the diet with the food to be included for the surgical client, including rationale for selections.

Unit 59 - Caring for the Patient with Oncologic Problems

Terminal Objective:

In the clinical setting, the learner will plan and administer comprehensive nursing care based on a knowledge of the physiological processes, the psychosocial impact and the community resources available to meet the individual needs of the client with oncologic problems.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:
1. Answer questions, on a teacher-made examination with no less than 75% accuracy, dealing with the functions of the American Cancer Society, the major classifications of neoplasms, the incidence of various malignancies, current methods of diagnoses and treatments, and appropriate nursing interventions to meet the general physical and emotional needs of the client with cancer.
2. List, on a teacher-made examination with no less than 75% accuracy, four major precautions necessary for self-protection and for the protection of others when caring for a client receiving radiotherapy.
3. Prepare drug cards from the drug list and answer study questions contained in a learning activity package relating to oncologic conditions with no less than 95% accuracy. The learner will complete post-test with no less than 75% accuracy.

Unit 60 - Nursing Support of the Aging Person

Terminal Objective:

In the clinical setting, the learner will assess, plan, implement, and evaluate care in terms of the individual's physical, social and psychological needs according to criteria established in assigned learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. List, on a teacher-made examination with no less than 75% accuracy, the principles of geriatric care.
2. Describe, on a teacher-made examination and/or on a written care plan with no less than 75% accuracy, changes of aging in relation to body systems.
3. Formulate plans of care, in small group settings, according to criteria established in related learning activities.
4. Describe, on a teacher-made examination and/or on a written care plan with no less than 75% accuracy, the physiological, psychological and sociological changes accompanying aging.
5. Develop a plan of care for an aged client with a cardiovascular disease, according to established criteria, relating plan to nursing care, activity, nutrition and usual treatment.

Unit 61 - Caring for the Client with a Disease or Disorder of the Integumentary System

Terminal Objective:

In the clinical setting, the learner will perform appropriate nursing measures to meet the individual needs of a client with a dermatological disorder or trauma according to standards defined in assigned learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Answer objective questions, on a teacher-made examination with no less than 75% accuracy, dealing with nursing observations and care of the normal skin, the psychosociological effects of skin disorders, the types and classifications of skin lesions, and nursing measures relevant to the various methods of treatment.
2. Prepare drug cards from the drug list and answer study questions contained in a learning activity package relating to the integumentary system with no less than 95% accuracy and answer post-test questions without aid of written materials with no less than 75% accuracy.

3. Answer study questions contained in a learning activity package concerning the nutritional aspects of conditions of the integumentary system with no less than 95% accuracy, and complete post-test with no less than 75% accuracy.
4. Plan and implement nursing care to meet the needs of a burned client based on an assessment of the extent of injury, a knowledge of possible complications, and of the effects of the burn on all body systems.

Unit 62 - Caring for the Patient with Disease or Disorder of the Respiratory System

Terminal Objective:

In the clinical setting, the learner will administer comprehensive nursing care to clients with the more common disorders of the respiratory system and related structures according to standards established in related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:
1. Identify, on a teacher-made examination in the clinical setting and on a nursing care plan with no less than 75% accuracy, intervention for clients with the more common disorders of the respiratory system and related structures.
2. Demonstrate, in the nursing arts laboratory and/or in the clinical setting with no less than 75% accuracy, the care of a client requiring closed chest drainage.
3. Identify and/or demonstrate, on a teacher-made examination with no less than 75% accuracy, the principles of postural drainage based on a knowledge of the normal respiratory tract.
4. Identify, on a teacher-made examination and/or in clinical experience with no less than 75% accuracy, diagnostic procedures as to purpose, client preparation and nursing intervention.
5. Prepare drug cards from the drug list and answer questions contained in a learning activity package relating to the respiratory system with no less than 95% accuracy and complete post-test with no less than 75% accuracy.

Unit 63 - Caring for the Client with a Disease or Disorder of the Digestive System

Terminal Objective:

In the clinical setting, the learner will administer comprehensive nursing care to meet the needs of the client with a disorder of the gastrointestinal tract and related structures, based on knowledge of specific disease entities and relevant nursing interventions, according to standards established in related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Answer questions, on a teacher-made examination with no less than 75% accuracy, dealing with normal anatomy and physiology, general signs and symptoms of dysfunction and nursing responsibilities related to diagnostic studies commonly performed in disorders of the digestive system.
2. Administer comprehensive nursing care to a client having a diagnostic study of the gastrointestinal tract or related structure, according to standards presented in related learning activities.
3. Answer questions, on a teacher-made examination with no less than 75% accuracy, relating to all pertinent aspects of treatment and nursing care of the client with disorders of the G-I system and related structures.

Unit 64 - Caring for the Client with a Disease or Disorder of the Cardiovascular System

Terminal Objective:

In the clinical setting, the learner will administer comprehensive nursing care to clients with the more common disorders of the cardiovascular system according to standards established in related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Identify, on a teacher-made examination with no less than 75% accuracy, causes, signs and symptoms, treatments, nursing intervention and prognosis of the more common disorders of the cardiovascular system.
2. Specify, on prepared drawings with no less than 90% accuracy, the cardiac circulation and conduction system and structure of the vessels.
3. Describe, on a teacher-made examination with no less than 75% accuracy, the cardiac regulatory mechanisms.
4. Outline, on a major nursing care plan, the care of a client with a myocardial infarction, demonstrating knowledge of the client and his condition by specific nursing intervention for disturbances in the physiological, psychological, environmental, and sociocultural needs according to standards established in related learning activities.
5. Identify, on samples of EKG strips, the death producing arrhythmias, with no less than 100% accuracy.
6. Identify, on a teacher-made examination and/or in the clinical setting with no less than 75% accuracy, diagnostic procedures as to purpose, client preparation and nursing intervention.

7. Describe, on a teacher-made examination with no less than 75% accuracy, the underlying pathophysiology of left and right heart failure, the signs and symptoms and nursing intervention utilized to alleviate the symptoms.
8. Identify, on a teacher-made examination and/or in the clinical setting with no less than 75% accuracy, specific nursing intervention for ischemia and edema, including observations of signs and symptoms, probable cause and alleviating measures.
9. Identify, on a teacher-made examination with no less than 75% accuracy, the proper techniques for cardiopulmonary resusitation.
10. Identify, on a teacher-made examination and/or on a written plan of care with no less than 75% accuracy, specific assessment and nursing intervention needed to care for a client with a blood dyscrasia, including dietary needs, safety needs and client teaching.
11. Prepare drug cards from the drug list and answer study questions contained in a learning activity package relating to the cardiovascular system with no less than 95% accuracy and complete post-test with no less than 75% accuracy.
12. Discuss, on a teacher-made examination with no less than 75% accuracy, the acceptable etiology and pathophysiology of the more common vascular disorders.

Unit 65 - Caring for the Client with a Disease or Disorder of the Urinary and Male Reproductive Systems

Terminal Objective:

In the clinical setting, the learner will administer comprehensive nursing care to a client with the more common disorders of the urinary and/or male reproductive system, according to criteria established in related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:
1. Locate on a diagram of the urinary and male reproductive tracts, with no less than 75% accuracy, each organ and part.
2. Identify, on a teacher-made examination or in clinical experience with no less than 75% accuracy, diagnostic procedures as to purpose, client preparation, and the desired nursing intervention.
3. Describe on self-prepared drug cards, with no less than 75% accuracy, the most frequently used urinary tract medications as to name, route, action, dosage, side effects and precautions.

4. Identify, on a teacher-made examination and/or on a written care plan, the nursing intervention for a client requiring urinary tract surgical treatment as prescribed in related learning activities.
5. Answer questions, on a teacher-made examination with no less than 75% accuracy, relating to the purpose and functions of renal dialysis and to specific nursing assessments and intervention for clients receiving renal dialysis therapy.
6. Provide nursing care to meet the individual needs of a client with problems of the male reproductive system based on knowledge and physiological process, the psychosociological impact and relevant nursing intervention. This care will be evaluated by the instructor as reflected in actual clinical application and/or on a teaching plan, and/or on a nursing care study.
7. Identify, on a teacher-made examination with no less than 75% accuracy, specific nursing assessment and intervention for the client with the nephritic syndrome based on knowledge of normal urinary function, specific signs and symptoms of problems, relief measures, client education, dietary needs, and long-range home care.

Unit 66 - Care of the Client with Endocrine Dysfunction

Terminal Objective:

The learner will administer, in the clinical setting, comprehensive nursing care to clients with a disease or disorder of the endocrine system according to criteria established in related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:
1. Describe, on a teacher-made examination with no less than 75% accuracy, the functions of the endocrine system.
2. Identify, on a teacher-made examination with no less than 75% accuracy, diagnostic tests as to types and purposes and/or implement appropriate nursing intervention to meet the needs of clients undergoing these tests during clinical assignments.
3. Describe, on a teacher-made examination and/or during clinical experience with no less than 75% accuracy, the signs and symptoms, treatment, and nursing action for the more common diseases and disorders of the endocrine system.
4. Compare, on a teacher-made examination with no less than 75% accuracy, the signs and symptoms of the different types of diabetes.
5. Describe, on a written care plan with no less than 75% accuracy, the nursing intervention needed when caring for a client with diabetes.

6. Describe, on a teacher-made examination and/or on a written care plan and/or during clinical assignments with no less than 75% accuracy, the importance of diagnostic tests used and nursing responsibilities for each.
7. Identify, on a teacher-made examination and/or during clinical experience with no less than 75% accuracy, signs and symptoms of acidosis, coma, ketoacidosis, and hypoglycemia and describe nursing care needed.
8. Present, during group discussion, a teaching plan covering all basic points in the care of a recently diagnosed diabetic, then implement this plan during clinical assignments. This plan will be written, utilizing principles of teaching in such a manner as to be clearly understood by all who read it.
9. Prepare drug cards from the drug list and answer study questions contained in a learning activity package relating to the endocrine system, with no less than 95% accuracy. A score of no less than 75% will be acceptable on post-test to be completed by the learner.
10. Structure diet planning and teaching to meet the specific needs of the diabetic client using a teaching format or in a one-to-one discussion, according to instructions from and to the satisfaction of the registered dietition.

Unit 67 - Caring for the Client with Gynecological Problem

Terminal Objective:

The learner will administer comprehensive nursing care to meet the individual needs of the client with a gynecological problem based on a knowledge of the physiological processes, the psychosocial impact, and the relevant nursing intervention based on criteria established in assigned learning activities. Client care will be evaluated in actual clinical setting, on a teaching plan and/or on a nursing care study.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:
1. Answer questions, on a teacher-made examination with no less than 75% accuracy, dealing with the normal anatomy and physiology of the female reproductive system, general signs and symptoms of gynecologic dysfunction, diagnostic tests, related treatment, and nursing responsibilities as presented in learning activities.
2. Prepare, instruct, and care for, in the clinical setting, a client having diagnostic studies of the female reproductive system and correlate test results with the patient's condition. The learner is evaluated through oral examination and nursing case studies.

3. Prepare drug cards from the drug list and answer study questions contained in a learning activity package relating to gynecology, with no less than 95% accuracy.
4. Instruct at least one female, in the clinical setting and/or community setting, in the importance and techniques of preventive aspects of disorders of the reproductive system.
5. Carry out appropriate nursing measures to meet the total needs of the client with a disorder of the female reproductive system, based on a knowledge of the physiological processes as well as the psychosocial impact on the client.
6. Answer questions, on a teacher-made examination with no less than 75% accuracy, dealing with the role of the nurse in the detection and treatment of all diseases of the breast with special emphasis on the physical and emotional needs of the client with breast disease as presented in lecture and reading assignments.
7. Carry out appropriate nursing measures to meet the total needs of the client with cancer of the breast, based on a knowledge of the physiological processes as well as the nurse's major role of emotional and physical rehabilitation.

Unit 68 - Caring for the Client with Musculoskeletal Dysfunction

Terminal Objective:

The learner will administer comprehensive nursing care to clients with the more common musculoskeletal diseases and disorders, according to criteria established in related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:
1. Relate, on a teacher-made examination with no less than 75% accuracy, the anatomy and physiology of the musculoskeletal system.
2. Describe, on a teacher-made examination with no less than 75% accuracy, types of casts and traction and the musculoskeletal disorders for which each is used.
3. Identify, during clinical experience and/or on a written care plan, according to criteria described in related learning activities, specific nursing care and observations necessary to meet the needs of a client who has had a cast applied and/or who is in traction.

4. Identify, on a teacher-made examination and/or in clinical practice with no less than 75% accuracy, diagnostic processes as to purpose, client preparation, and the desired nursing intervention.
5. Describe, on a teacher-made examination and/or on a written care plan, according to standards established in related learning activities, the physiology of musculoskeletal trauma and specific treatment, nursing intervention, and emergency measures used in each.
6. Describe, on a teacher-made examination with no less than 75% accuracy, and/or on a written care plan and/or implement during clinical practice, the care needed for a client who has had an amputation.
7. Describe, on a teacher-made examination or during clinical experience, the specific nursing care for a client with arthritis. This will entail a recall of the pathophysiology of the more common types of arthritic conditions and a comparison of the treatments and drug therapy needed to the specific type of disease entity according to the principles developed during the course.
8. Identify, on a teacher-made examination with no less than 75% accuracy, the principles of rehabilitation as presented in related learning activities.
9. Identify, on a teacher-made examination and/or on a written care plan with no less than 75% accuracy, the nutritional needs of a client with a musculoskeletal dysfunction. References and notes may be used and up to 24 hours may be taken for the preparation of this assignment.

Unit 69 - Caring for the Client with Diseases or Disorders of the Eye and Ear

Terminal Objective:

In the clinical setting, the learner will administer comprehensive nursing care to clients with the more common diseases or disorders of the eye and ear according to criteria established in related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:
1. Describe, on a teacher-made examination with no less than 75% accuracy, the basic anatomy and physiology of the eye and ear.

2. Identify, on a written care plan with no less than 75% accuracy, the specific diagnostic tests and treatments for the more common conditions of the eye and ear and relate the appropriate nursing action needed in each instance.
3. Identify, on a teacher-made examination and/or a written care plan, according to criteria presented in related learning activities, signs, symptoms, treatment and related nursing care for those conditions which impair the function of the eye and ear.
4. Correctly administer, during clinical experience and/or laboratory demonstration, eye and ear medications. This necessitates a knowledge of the action, usual dosage, contraindications, and side effects of the more common medications for the eye and ear.
5. Identify, on a teacher-made test and/or on a written care plan with no less than 75% accuracy, the signs, symptoms, treatments, and related nursing care of those conditions which may lead to blindness and describe the nursing intervention needed in each instance.

Unit 70 - Caring for the Client with a Disease or Disorder of the Nervous System

Terminal Objective:

The learner will administer comprehensive nursing care to clients with the more common diseases or disorders of the nervous system and list the more common disorders according to criteria established in related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:
1. Compare, on a teacher-made examination with no less than 75% accuracy, the primary action of the central, peripheral, and autonomic nervous system with the signs and symptoms of the more common neural regulatory disorders.
2. Relate, on a teacher-made examination and/or a written care plan with no less than 75% accuracy, the purpose of the more common diagnostic tests to the nurse's role and responsibility during tests.
3. Relate, in group discussion, cause of headaches to treatment and nursing care needed.
4. Identify, on a teacher-made examination and/or on a written care plan with no less than 75% accuracy, signs and symptoms of sensorium changes and their major causes.
5. Identify, in clinical practice and/or on a teacher-made examination with no less than 75% accuracy, treatment and drug therapy for clients with sensorium alteration and administer appropriate nursing care.

6. Describe, on a written care plan with no less than 75% accuracy, the emotional needs of the client with central nervous system disturbances and nursing care needed to meet these needs.
7. Identify, on a teacher-made examination and/or on a written care plan with no less than 75% accuracy, safety measures and observations to be made when caring for a client who is having a seizure. Implement appropriate measures during clinical practice.
8. Describe, in group discussions and/or on a written care plan, and/or during clinical experience, the extent to which emotional and socioeconomic factors affect the client with a convulsive disorder and implement care needed.
9. Identify, on a teacher-made examination and/or written care plan with no less than 75% accuracy, signs and symptoms of the more common degenerative disorders and describe physiological processes of these diseases.
10. Specify, during group discussion or during clinical experience, appropriate nursing actions, including rehabilitation teaching, necessary to meet the needs of the client with a degenerative disease of the nervous system.
11. Prepare drug cards from the drug list and answer study questions contained in a learning activity package relating to disorders of the nervous system with no less than 95% accuracy and complete a post-test scoring no less than 75% accuracy.
12. Identify, on a teacher-made examination and implement in the clinical setting, the priority nursing needs of the unconscious or physically dependent client according to standards established in related learning activities.

MATERNAL AND CHILD HEALTH NURSING

Unit 71 - Introduction, History, and Trends of Maternal and Child Health Nursing

Terminal Objective:

The learner will identify, on a teacher-made examination with no less than 75% accuracy, the goals of maternity care and their relationship to the concept of the family in contemporary society.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Contrast, on a teacher-made examination with no less than 75% accuracy, the leading causes of infant and maternal death today with that of 25 years ago.
2. Describe, on a teacher-made examination with no less than 75% accuracy, the services rendered by no less than three agencies involved in providing maternal and child health services from each of the following levels: national, state, and local.
3. Discuss, in small group settings, the influence of environment and culture on the family utilizing no less than three outside sources.
4. Identify, on a teacher-made examination with no less than 75% accuracy, five significant persons in the history of obstetrics and their major contribution to the advancement of maternity nursing.

Unit 72 - The Antepartal Period

Terminal Objective:

In the clinical setting with instructor supervision, explain to a client, with no less than 90% accuracy, the recommended regimen for a safe, healthy pregnancy, utilizing instructor-recommended teaching aids.

Upon completion of this unit of study, the learner will:

1. Identify, on prepared drawings of the male and female reproductive systems, with 90% accuracy, the organs of reproduction and the reproductive function of each.
2. Describe, on a teacher-made examination with no less than 75% accuracy, the shape and size of the normal and abnormal pelvis and its relationship to vaginal delivery.
3. Answer objective questions, on a teacher-made examination with no less than 75% accuracy, regarding fertilization, implantation, and stages of fetal growth and development.

4. Categorize, on a teacher-made examination with no less than 75% accuracy, the signs, symptoms and diagnostic tests of pregnancy.
5. Identify, on a teacher-made examination, no less than 75% of the normal physiological changes and prescribed care of pregnancy as presented in assigned learning activities.
6. Differentiate, on a teacher-made examination with no less than 75% accuracy, between the examinations carried out when pregnancy is established and those of subsequent prenatal visits.
7. Plan, in an independent out-of-class activity, a balanced diet for a pregnant woman covering a one-week period. This diet will be objectively evaluated by the instructor for accuracy and completeness.
8. Identify, on a teacher-made examination with no less than 75% accuracy, the discomforts and complications of pregnancy and the nursing implications of each.

Unit 73 - The Intrapartal Period

Terminal Objective:

In the clinical setting, the learner will administer comprehensive nursing care to the client and her family during the four stages of labor according to standards established in related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Identify, on a teacher-made examination with no less than 75% accuracy, and evaluate in the clinical setting, the stage of labor and condition of the client and fetus at all times during the parturient period and provide appropriate nursing intervention based on criteria presented in related learning activities.
2. Answer objective questions, on a teacher made examination with no less than 75% accuracy, regarding fetal position, presentation and lie.
3. Admit the client and administer nursing measures necessary to prepare her for delivery under direct instructor supervision.
4. Prepare the delivery room and the client for delivery using aseptic and sterile techniques, under direct instructor supervision.
5. Discuss on a teacher-made examination, and identify in the clinical setting, with no less than 75% accuracy, obstetric drugs and anesthetics and their effects on maternal and fetal physiology during the intrapartal period.

6. Evaluate the condition of the newborn infant and institute appropriate nursing action in the delivery room under direct instructor supervision.
7. Institute appropriate nursing action to meet the immediate needs of the post-partal mother under direct supervision of instructor.
8. Identify, on a teacher-made examination with no less than 75% accuracy, various operative procedures and nursing implications utilized in delivery.
9. Identify, on a teacher-made examination with no less than 75% accuracy, and recognize in the clinical setting, deviations from the normal labor process and initiate appropriate nursing action.

Unit 74 - The Post-partal Period

Terminal Objective:

In the clinical setting, the learner will administer comprehensive nursing care to the client during the post-partal period according to standards established by related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:
1. Identify, on a teacher-made examination with no less than 75% accuracy, the normal and abnormal involutional process and, in the clinical setting, institute appropriate nursing interventions according to criteria established in related learning activities.
2. Instruct at least one client in regard to her personal and infant's care utilizing a written teaching plan according to standards established in related learning activities.
3. Provide instruction for the client regarding available sources of follow-up care for herself and her infant according to standards established in related learning activities.

Unit 75 - The Newborn Child

Terminal Objective:

The learner will administer comprehensive care to the normal newborn during the period of hospitalization according to standards established in related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:
1. Differentiate, on a formative evaluation with no less than 75% accuracy, between normal and abnormal characteristics and physiology of the newborn.

2. Admit, under direct instructor supervision, at least one newborn to the nursery making essential observations, performing recommended nursing procedures, and accurately recording all relevant data.
3. List, on a teacher-made examination with no less than 75% accuracy, and perform in the clinical setting, essential daily care and feeding of the normal newborn according to criteria established in related learning activities.
4. Display competencies in the role of an assistant to the registered nurse in giving select care to high-risk infants based on criteria established in related learning activities.

PSYCHIATRIC NURSING

Unit 76

Terminal Objective:

In the clinical setting and/or community setting, the learner will identify her own attitude and function effectively as a member of the health team in care of emotionally disturbed clients according to criteria established in related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Trace, on a teacher-made examination with no less than 75% accuracy, the history of psychiatry from ancient to modern times, relating early care to modern care.
2. Discuss in small groups, according to established criteria for group participation, legal aspects of psychiatric nursing and the relationship of specific clinical assignments to these issues.
3. Record in a daily diary an assessment of the client's behavior and the principles of psychiatric nursing utilized to cope with this behavior as well as the principles applied to resultant behavior, according to established criteria.
4. Identify from a client situation on a teacher-made examination with no less than 75% accuracy, mental mechanisms and methods of coping or dealing with behavior.
5. Discuss, in small groups, behavior of specific clients and types of nursing intervention techniques used to cope with the behavior based on material presented in assigned learning activities.
6. Discuss, in post-conferences in the hospital setting, desired and undesired effects of psychotrophic medication administered to assigned clients according to established criteria.

7. Develop a plan of care for a client demonstrating projective reactions according to standards established in related learning activities.
8. Develop a plan of care for a client demonstrating autistic reactions based on criteria presented in related learning activities.
9. Explore through role play, various ways of coping with clients demonstrating affective disorders. This includes planning and execution of appropriate nursing measures according to established standards in related learning activities.
10. Identify, in the clinical setting and/or on a written care plan, various modes of defense utilized by the client demonstrating patterns of psychoneurotic behavior and nursing measures indicated by the specific behavior, according to criteria established in related learning activities.
11. Plan, in small group discussions and/or in the clinical setting, nursing intervention based on the client's emotional needs as expressed by somatic illness, according to criteria established in related learning activities.
12. Plan and implement appropriate nursing measures for coping with clients with character disorders based on explorations of personality structures as well as physiologic dysfunctions, according to criteria established in related learning activities.
13. Explore in small groups deviate behavior patterns of childhood and factors necessary in coping with disturbed children based on criteria presented in related learning activities.
14. Relate to the behavior of the emotionally disturbed adolescent, in the clinical setting and/or on a written care plan, according to criteria established in related learning activities.

Unit 77 - Vocational Adjustments

Terminal Objective:

In the clinical setting the learner will work effectively as a team member, being well groomed, communicating effectively and behaving in a manner that reflects understanding of the concepts of vocational growth and code of ethics for the nurse.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:
1. Outline, on a teacher-made examination with no less than 75% accuracy, the organizational structure of a school and clinical facility.

2. Define, on a teacher-made examination with no less than 75% accuracy, the role of the practical nurse on the health team.
3. Define, on a teacher-made examination with no less than 75% accuracy, the role and functions of nursing organizations.
4. Identify, on a teacher-made examination with no less than 75% accuracy, the professional and civic organizations which enhance growth as a nurse and as a person.
5. Apply for and resign from a position by letter with no less than 75% accuracy, in a hypothetical situation.
6. Discuss, in small groups, job opportunities available according to criteria outlined for group discussions.

EXIT PRACTICAL NURSE

ADVANCED NURSING OF ADULTS AND CHILDREN

Unit 78 - Medical-Surgical Nursing of Adults and Children II

Terminal Objective:

In the clinical setting, the learner will administer comprehensive nursing care to a client with the less common conditions of each of the body systems and/or multiple problem entities requiring a greater degree of judgment on the part of the nurse according to criteria established in related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Relate, on a teacher-made examination with no less than 80% accuracy, and administer in the clinical setting, comprehensive nursing care to clients requiring complex nursing judgment based on a knowledge of the symptomatology, etiology, diagnosis, treatment modalities, and prognosis of the specific disease entities.

   Note: Venipuncture and nasogastric tube insertion are to be taught at this time. Suggested reference: Wood's Nursing Skills for Allied Health Services. Volume 3, page 307.

Unit 79 - Disaster and Emergency Nursing

Terminal Objective:

In the clinical setting, according to established criteria, the learner will administer comprehensive care as a team member to clients and families in an emergency nursing situation.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Identify, on a teacher-made examination and/or in the clinical setting with no less than 75% accuracy, the principles of nursing care of clients involved in disaster or emergency situations, and services offered on an emergency basis in the local community.
2. Demonstrate, in the clinical setting, the ability to register clients according to hospital policy.
3. Evaluate the client's condition and institute appropriate nursing measures according to criteria established in related learning activities.
4. Identify, on a teacher-made examination with no less than 80% accuracy, the nature and characteristics of disasters and agencies concerned with the prevention of and care in disasters.
5. Prepare drug cards from the drug list and answer study questions contained in a learning activity package relating to disaster and emergency nursing with no less than 95% accuracy and complete post-test without aid with no less than 80% accuracy.

Unit 80 - Nursing of Adults and Children in Special Care Areas

Terminal Objective:

In the clinical settings, the learner will participate as a team member administering comprehensive care to acute or critically ill clients who require the services of a specialized nursing area, according to criteria established in related learning activiites.

Performance Objective and Criterion-Referenced Measure:

Upon completion of this unit of study, the learner will:

1. Explain, on a teacher-made examination or on written work, and utilize in the clinical setting, special equipment and procedures which are an essential part of the overall administration of comprehensive nursing care to clients in specialized nursing care areas (i.e. surgical intensive care unit, medical intensive care unit, cardiac care unit, renal dialysis unit, burn unit, neonatal intensive care unit, or recovery room, etc.).

Unit 81 - Decision Making in Nursing

Terminal Objective:

In the clinical setting, the learner will apply at a beginning level, the skills and techniques for problem solving, decision making, and coordination which are basic to the management of client care according to criteria established in related learning activities.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Compare observed client interactions with standards for decision making as presented in related learning activities. This comparison will involve the use of records, reports, personal observation, audits, tests and surveys, and will be carried out on a teacher-made examination with no less than 80% accuracy.
2. Implement the nursing process, in the clinical setting, according to established standards for AD nursing practice, through collaboration and cooperation with, and coordination of the activities of other members of the health care team.

Unit 82 - Professional Adjustments

Terminal Objective:

On a teacher-made examination with no less than 80% accuracy, the learner will identify the roles and responsibilities of the associate degree nursing graduate within the legal and ethical standards of the nursing profession.

Performance Objectives and Criterion-Referenced Measures:

Upon completion of this unit of study, the learner will:

1. Interpret the role and responsibilities of an associate degree nurse, in a written report according to criteria established in related learning activities.
2. Write a personal philosophy of nursing, in out-of-class activity, without the aid of any resource material.
3. Identify, on a teacher-made examination with no less than 80% accuracy, the legal rights and responsibilities of a professional nurse.
4. Compose independently, a vita for employment and letters of application and resignation, according to criteria established in class presentations and resource readings.
5. Relate personal observations of the proceedings of at least one District Nurses' Association Meeting including the structure and primary functions of the organization utilizing the provided format for a formal report.

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APPENDIX A

APPENDIX A

ANA STANDARDS OF NURSING PRACTICE*

Standards of Nursing Practice

Standard I - The collection of data about the health status of the client/patient is systematic and continuous. The data are accessible, communicated, and recorded.

Rationale: Comprehensive care requires complete and ongoing collection of data about the client/patient to determine the nursing care needs of the client/patient. All health status data about the client/patient must be available for all members of the health care team.

Assessment Factors:

1. Health status data include:
   - Growth and development
   - Biophysical status
   - Emotional status
   - Cultural, religious, socioeconomic background
   - Performance of activities of daily living
   - Patterns of coping
   - Interaction patterns
   - Client's/patient's perception of the satisfaction with his health status
   - Client/patient health goals
   - Environment (physical, social, emotional, ecological)
   - Available and accessible human and material resources
2. Data are collected from:
   - Client/patient, family, significant others
   - Health care personnel
   - Individuals within the immediate environment and/or the community
3. Data are obtained by:
   - Interview
   - Examination
   - Observation
   - Reading records, reports, etc.
4. There is a format for the collection of data which:
   - Provides for a systematic collection of data
   - Facilitates the completeness of data collection

"ANA Standards of Nursing Practice", The American Nurse, July, 1974. pp. 11-22.

5. Continuous collection of data is evident by:
   - Frequent updating
   - Recording of changes in health status
6. The data are:
   - Accessible on the client/patient records
   - Retrievable from record-keeping systems
   - Confidential when appropriate

Standard II - Nursing diagnoses are derived from health status data.

Rationale: The health status of the client/patient is the basis for determining the nursing care needs. The data are analyzed and compared to norms when possible.

Assessment Factors:

1. The client's/patient's health status is compared to the norm in order to determine if there is a deviation from the norm and the degree and direction of deviation.
2. The client's/patient's capabilities and limitations are identified.
3. The nursing diagnoses are related to and congruent with the diagnoses of all other professionals caring for the client/patient.

Standard III - The plan of nursing care includes goals derived from the nursing diagnoses.

Rationale: The determination of the results to be achieved is an essential part of planning care.

Assessment Factors:

1. Goals are mutually set with the client/patient and pertinent others:
   - They are congruent with other planned therapies.
   - They are stated in realistic and measurable terms.
   - They are assigned a time period for achievement.
2. Goals are established to maximize functional capabilities and are congruent with:
   - Growth and development
   - Biophysical status
   - Behavioral patterns
   - Human and material resources

Standard IV - The plan of nursing care includes priorities and the prescribed nursing approaches or measures to achieve the goals derived from the nursing diagnoses.

Rationale: Nursing actions are planned to promote, maintain, and restore the client's/patient's well-being.

Assessment Factors:

1. Physiological measures are planned to manage (prevent or control) specific patient problems and are related to the nursing diagnoses and goals of care, e.d. ADL, use of self-help devices, etc.
2. Psychosocial measures are specific to the client's/patient's nursing care problem and to the nursing care goals, e.g. techniques to control aggression, motivation.
3. Teaching-learning principles are incorporated into the plan of care and objectives for learning stated in behavioral terms, e.g. specification of content for learner's level, reinforcement, readiness, etc.
4. Approaches are planned to provide for a therapeutic environment:
   - Physical environmental factors are used to influence the therapeutic environment, e.g. control of noise, control of temperature, etc.
   - Psychosocial measures are used to structure the environment for therapeutic ends, e.g. paternal participation in all phases of the maternity experience.
   - Group behaviors are used to structure interaction and influence the therapeutic environment, e.g. conformity, ethos, territorial rights, locomotion, etc.
5. Approaches are specified for orientation of the client/patient to:
   - New roles and relationships
   - Relevant health (human and material) resources
   - Modifications in plan of nursing care
   - Relationship of modifications in nursing care plan to the total care plan
6. The plan of nursing care includes the utilization of available and appropriate resources:
   - Human resources--other personnel
   - Material resources
   - Community
7. The plan includes an ordered sequence of nursing actions.
8. Nursing approaches are planned on the basis of current scientific knowledge.

Standard V - Nursing actions provide for client/patient participation in health promotion, maintenance and restoration.

Rationale: The client/patient and family are continually involved in nursing care.

Assessment Factors:

1. The client/patient and family are kept informed about:
   - Current health status
   - Changes in health status
   - Total health care plan
   - Nursing care plan
   - Roles of health care personnel
   - Health care resources
2. The client/patient and family are provided with the information needed to make decisions and choices about:
   - Promoting, maintaining and restoring health
   - Seeking and utilizing appropriate care personnel
   - Maintaining and using health care resources

Standard VI - Nursing actions assist the client/patient to maximize his health capabilities.

Rationale: Nursing actions are designed to promote, maintain and restore health.

Assessment Factors:

1. Nursing actions:
   - Are consistent with the plan of care
   - Are based on scientific principles
   - Are individualized to the specific situation
   - Are used to provide a safe and therapeutic environment
   - Employ teaching-learning opportunities for the client/patient
   - Include utilization of appropriate resources
2. Nursing actions are directed by the client's/patient's physical, physiological, psychological and social behavior associated with:
   - Ingestion of food, fluid and nutrients
   - Elimination of body wastes and excesses in fluid
   - Locomotion and exercise
   - Regulatory mechanisms--body heat, metabolism
   - Relating to others
   - Self-actualization

Standard VII - The client's/patient's progress or lack of progress toward goal achievement is determined by the client/patient and the nurse.

Rationale: The quality of nursing care depends upon comprehensive and intelligent determination of nursing's impact upon the health status of the client/patient. The client/patient is an essential part of this determination.

Assessment Factors:

1. Current data about the client/patient are used to measure his progress toward goal achievement.
2. Nursing actions are analyzed for their effectiveness in the goal achievement of the client/patient.
3. The client/patient evaluates nursing actions and goal achievement.
4. Provision is made for nursing follow-up of a particular client/patient to determine the long-term effects of nursing care.

Standard VIII - The client's/patient's progress or lack of progress toward goal achievement directs reassessment, reordering of priorities, new goal setting and revision of the plan of nursing care.

Rationale: The nursing process remains the same, but the input of new information may dictate new or revised approaches.

Assessment Factors:

1. Reassessment is directed by goal achievement or lack of goal achievement.
2. New priorities and goals are determined and additional nursing approaches are prescribed appropriately.
3. New nursing actions are accurately and appropriately initiated.

Standards of Community Health Nursing Practice

Standard I - The collection of data about the health status of the consumer is systematic and continuous. The data are accessible, communicated and recorded.

Rationale: Data collection is prerequisite to a realistic assessment for providing comprehensive care. Present and future health of individuals, families and communities is influenced by global and universal factors. Man-environment interrelationships determine status of health and survival.

Assessment Factors:

1. Health status data include:
   - Individuals and families
     - Growth and development
     - Biophysical status
     - Emotional status
     - Cultural, religious, socioeconomic and occupational background

Performance of activities of daily living
Patterns of coping
Interaction patterns, family dynamics
Consumer's perception of and satisfaction with his health status
Consumer's health status
Relevant codes, statutes, regulations, contracts and agreements
Environment (physical, social, emotional, ecological)
Available and accessible human and material resources

- Groups and communities
  Community dynamics
  Power structures (legislative, political, decision making)
  Economic and cultural considerations, values
  Demographic data
- Groups and communities
  Information derived from current, local, national and international studies of disease surveillance

2. Data are collected from:
   - Individual consumers
   - Family and significant others
   - Health care providers
   - Individuals and groups within the immediate environment and the community
   - Relevant scientific literature and studies
3. Data are obtained by:
   - Interview
   - Examination
   - Observation
   - Surveys
   - Reading reports, records, etc.
4. There is a data collection method which provides for:
   - Systematic collection
   - Completeness
   - Frequent updating of changes in the health status
   - Retrievability from record-keeping systems
   - Confidentiality when appropriate

Standard II - Nursing diagnoses are derived from health status data.

Rationale: Current knowledge derived from the biological, psychological and social sciences; ecology; clinical nursing and community organizations is utilized in making nursing diagnoses. The totality of health issues and social issues and the identification of component problems within the situation are considered. Health status data provide the basis for determining the kinds of nursing actions to be taken.

Assessment Factors:

1. Health status evaluation is based on the identification of health needs.
2. Health status evaluation includes the availability of resources and the patterns of delivery of health care.
3. Potentials and limitations are identified.
4. The health status data are analyzed and selectively applied in arriving at a diagnosis.

Standard III - Plans for nursing service include goals derived from nursing diagnoses.

Assessment Factors:

1. Goals are mutually set with consumers and relevant others.
2. Goals are congruent with other planned approaches.
3. Goals are stated in realistic and measurable terms.
4. Goals are assigned a time period for achievement.
5. Goals are consistent with human and material resources.

Standard IV - Plans for nursing service include priorities and nursing approaches or measures to achieve the goals derived from nursing diagnoses.

Rationale: In order to approach nursing service in a systematic manner and to achieve the goals of the nursing care plan, priorities must be established and specific nursing actions determined.

Assessment Factors:

1. Primary, secondary and tertiary measures are planned to meet specific consumer needs and are related to nursing diagnoses and goals of service.
2. Teaching-learning principles are incorporated into the plan of care. Objectives for learning are stated in behavioral terms; reinforcement is planned; readiness is considered, and the content is at the learner's level.
3. Approaches are specified for orientation of groups and communities to changing roles and life styles and patterns of health care delivery.
4. The plan includes the utilization of available and appropriate human and material resources.
5. The plan is flexible and includes an ordered sequence of nursing actions.
6. Nursing approaches are planned on the basis of current scientific knowledge.

Standard V - Nursing actions provide for consumer participation in health promotion, maintenance and restoration.

Rationale: Active involvement of the individual, family and community is necessary in attainment of positive health and independent decision making relating to high-level wellness.

Assessment Factors:

1. The consumer and nurse share information about:
   - Current health status
   - Changes in health status
   - Total health care plan
   - Nursing care plan
   - Roles of health care personnel
   - Health care resources
2. The consumer is provided with the data needed to make informed decisions about:
   - Promoting, maintaining and restoring health
   - Seeking and utilizing appropriate health care services
   - Maintaining and using health care resources
3. The consumer is supported in making independent judgements and decisions, implementing plans and seeking assistance when needed.

Standard VI - Nursing actions assist consumers to maximize health potential.

Rationale: Maximizing consumers' health potential depends on nursing actions purposefully directed toward promotion, maintenance and restoration. The interrelatedness of growth with the dynamic entirety of health and wellness throughout the life span contributes to man's satisfaction and achievement in living.

Assessment Factors:

1. Nursing actions are consistent with the nursing plan.
2. Nursing actions are based on scientific principles.
3. Nursing actions are individualized to the specific situation.
4. Nursing actions promote a safe, healthful and therapeutic environment.
5. Nursing actions provide opportunities for consumer learning and participation.
6. Nursing actions utilize appropriate resources.
7. Nursing actions influence consumer's physiological, psychological and social behaviors that maximize health potential. Nursing actions are directed in order to influence community actions as well as the behaviors of individuals.

Standard VII - The consumer's progress toward goal achievement is determined by the consumer and the nurse.

Rationale: The effectiveness of nursing service depends on comprehensive and intelligent determination of the impact of nursing on the health status of consumers.

Assessment Factors:

1. Baseline and current data about the consumer are used in measuring progress toward goal achievement.
2. Nursing and consumer actions are mutually analyzed and evaluated for their effectiveness toward goal achievement.

Standard VIII - Nursing actions involve ongoing reassessment, reordering of priorities, new goal setting and revision of the nursing plan.

Rationale: The input of new information, changes, or lack of progress in the consumer situation requires re-analysis and may dictate new or revised approaches, including termination of services.

Assessment Factors:

1. Reassessment is an ongoing process in evaluating goal achievement or lack of goal achievement.
2. New priorities and goals are determined by the nurse and consumer.
3. Alternative actions are identified and mutually initiated.
4. Termination of service is based on reassessment and evaluation.
5. Provision is made for follow-up of particular consumers, groups and communities to determine the long-term effects of nursing services.

Standards of Geriatric Nursing Practice

Standard I - The nurse demonstrates an appreciation of the heritage, values and wisdom of older persons.

Rationale: The nurse has some understanding and appreciation of the social and historic settings in which older people have developed and how these factors may affect their behavior and values. This enables her to respect the older person as an individual and provides for enrichment of the nurse's life. Such an appreciation also provides ways in which the nurse can point out how the present generation has built on their foundation, thus helping to keep older persons in the present.

Assessment Factors:

1. The nurse helps older persons share their experiences and talents with the present generation.
2. The nurse respects the older person's right to practice religion as he desires.

3. The nurse accepts the older person's desire to cling to a particular item, such as a piece of jewelry or a photograph.
4. The nurse accepts the older person's right to wear the clothes he is accustomed to wearing, such as a night cap or long underwear.

Standard II - The nurse seeks to resolve her conflicting attitudes regarding aging, death and dependency so that she can assist older persons and their relatives to maintain life with dignity and comfort until death ensues.

Rationale: If the nurse does not recognize and seek to resolve conflicts regarding aging, death and dependency, functioning can be impaired and personal satisfaction not be achieved from her work. These conflicts are resolved to enable the nurse to enlarge her capacity to express empathy and compassion.

Dying and death are common emotional and stressful experiences. Preparation for death is an imminent developmental task of old age. The older person is more frequently exposed to dying and death. The nurse needs to assist older persons, personnel, relatives and other persons who are experiencing dying, death and bereavement in order that they may express their feelings, thoughts and rituals.

Rituals provide a socially acceptable way of coping with emotion; therefore, the nurse enables the older person to participate in rituals meaningful to him.

Assessment Factors:

1. The nurse recognizes that the dependency-independency conflict is perpetuated throughout life.
2. The nurse recognizes that many of her own attitudes concerning death and dying are learned from the culture of the society in which she lives.
3. The nurse freely shares her feelings about her attitude toward aging and death with colleagues or other individuals.
4. The nurse recognizes the many ways of coping with death.
5. The nurse calls the appropriate religious advisor or provides for last rites.
6. Upon request or other indication, the nurse assists in the preparation for dying, making of the will, plans for burial and notification of other persons.

Standard III - The nurse observes and interprets minimal as well as gross signs and symptoms associated with both normal aging and pathologic changes and institutes appropriate nursing measures.

Rationale: In older persons, pathology may be ignored because their symptoms may be ascribed to the normal aging process. Older persons do not attend to and are frequently not able to express or recognize the importance of symptoms. They have lived with some symptoms, such as pain, for a long time and have adapted to it. As a result, they either ignore or exaggerate the symptoms. Sensory and cognitive changes are often slowly progressive and may be ignored until the adaptive response of the aged may interfere with functions or health, such as a personality change due to progressive loss of hearing.

Assessment Factors:

1. Falling, irritability, or slight speech changes may be a sign of cerebral disturbance.
2. Confusion may be caused by medication, dehydration, or excessive fatigue. Mild confusion may be the first indication of pneumonia.
3. Edema may result from prolonged sitting or it may be a sign of either a cardiovascular problem or electrolyte imbalance.

Standard IV - The nurse differentiates between pathologic social behavior and the usual life style of each aged individual.

Rationale: In all human beings, there is a continuum of behavior which is within the range of normal. It is difficult to discriminate between that which is normal and that which can be dangerous to the individual or others, such as the right of the person for privacy and its extreme, which is withdrawal, and a person's right to independence and its extreme which may also be pathologic.

Assessment Factors:

1. The nurse visiting in the home may observe poor maintenance of the home and a lack of cleanliness. The nurse assesses the situation to determine whether this has always been the person's life style or whether his behavior has changed.
2. Many older persons who have been useful and needed throughout their lives may resent being given "busy work."
3. Withdrawal may or may not be a coping mechanism.
4. An older person who is used to independence and self-direction, may become mildly confused when placed in an institution. Such agitation may result in the older person making unusual demands. The nurse must not automatically see this as senility, but rather determine whether it might be an effort to maintain a life style that is being threatened.
5. The nurse provides healthy outlet of normal sexual drives within the individual's life style and environmental settings, such as opportunities for heterosexual activities.

6. The nurse assists older persons to develop and maintain their social contacts, both inside and outside the institution or dwelling. This may take the form of telephone calls, birthday cards, etc. These activities may be provided by voluntary services.

Standard V - The nurse supports and promotes normal physiologic functioning of the older person.

Rationale: The nurse helps the older person to experience a higher level of wellness and seeks to prevent iatrogenic conditions.

Assessment Factors:

1. The nurse makes use of selected foods, fluids, exercise and habit training instead of cathartics, enemata and other artificial means for bowel regulation.
2. The nurse uses back rubs and gentle massage and other nursing measures as possible alternatives for medication to encourage sleep.
3. The nurse is aware of the increased dryness and fragility of an older person's skin so that less frequent bathing is indicated.
4. The nurse allows sufficient time for the client/patient to perform his activities of daily living at his own pace.

Standard VI - The nurse protects aged persons from injury, infection and excessive stress and supports them through the multiplicity of stressful experiences to which they are subjected.

Rationale: Aged persons have a decreased margin of compensatory reserve and, therefore, are more vulnerable to secondary problems as a result of stressful experience.

Assessment Factors:

1. Because the older person frequently has a variety of chronic illnesses, an acute episode will often exacerbate a chronic illness. When pneumonia occurs the older individual frequently develops cardiac decompensation or his diabetes becomes unregulated. The nurse must recognize early symptoms or even the potential for decompensation and provide the preventive rest and dependence.
2. The nurse uses appropriate precautions to preventive self-mutilation, suicide and assaultive behavior.
3. When an older person has a fractured femur, unless early mobility is provided, he frequently develops complicating conditions such as incontinence, confusion, social withdrawal and decubitus ulcers.

Standard VII - The nurse employs a variety of methods to promote effective communication and social interaction of aged persons with individuals, family and other groups.

Rationale: Communication is essential to mental health and social well-being. Older persons need all kinds of sensory stimulation as well as a higher intensity of such stimulation. They frequently experience barriers in communication, such as language difference, aphasia, deafness, edentulousness or sensory loss.

Assessment Factors:

1. Older blind persons may be able to use talking books and other devices.
2. The nurse uses touch as a nonverbal means to communicate purposefully an idea or feeling.
3. The nurse makes a special effort to get and hold the older person's attention by eye contact, pitch of voice and/or objects which improve her communication with older persons.
4. The nurse uses clocks, calenders, newspapers, reading materials, thermometers and holiday decorations to assist in the orientation and stimulation of older persons to time and events.
5. The nurse plans and creates situations so that interaction is encouraged, such as placing an older person in a wheelchair near the nurse's desk so that he can observe, or thoughtfully selecting roommates and caring personnel.
6. The nurse is aware of obstacles that may interrupt the communication process between the nurse and an older person.
7. Music is a universal language; therefore, it may be used on an individual basis or as group activity to promote interaction.

Standard VIII - The nurse together with the older person designs, changes or adapts the physical and psychosocial environment to meet his needs within the limitations imposed by the situation.

Rationale: The health of the older person is greatly influenced by his environment. The nurse uses this environment as a therapeutic tool. His environment may be monotonous because his mobility is reduced. The nurse, therefore, provides for variety in his environment.

The older person who has increasing dependence still has a need for maintaining a degree of mastery of his physical and psychosocial environment.

Assessment Factors:

1. The nurse provides a variety of materials for the older person's creativity, manipulation and sensory stimulation.
2. The nurse suggests the installation of hand rails in buildings used by aged persons.
3. The nurse changes the location of a client's/patient's bed so he may look out of the window.
4. The nurse provides the opportunities for learning which expand the horizons of older persons.
5. The nurse teaches the family to avoid many sudden changes in the environment. Often the most simple change of furniture is upsetting.

Standard IX - The nurse assists older persons to obtain and utilize devices which help them attain a higher level of function and ensures that these devices are kept in good working order by the appropriate persons or agencies.

Rationale: Devices are essential supportive measures to facilitate function. A nonfunctioning or defective device is potentially dangerous. To help older persons be more independent, the nurse teaches them to secure, to use and to maintain their devices.

Older persons have proportionately greater need for one or more assistive devices to facilitate functioning; therefore, the nurse needs to be well informed about resources for obtaining and maintaining these devices.

Assessment Factors:

1. If a hearing aid is required, the nurse considers the problem of cost and, if necessary, contacts a community agency. When a hearing aid is fitted for the older person, the nurse assists him in his adjustment to it by recognizing fatigue and that it takes time to get used to a hearing aid.
2. The nurse uses other resource persons to help design and fit wheelchairs and to adapt and maintain this equipment.
3. Following a cerebral vascular accident, the older person may need to adjust to using a cane, foot-drop brace, hearing aid and special eating devices.
4. The use of some devices, such as a hydraulic lift, may be primarily for the benefit of personnel and the older person may need a great deal of reassurance and instruction to perceive the mutual benefit obtained.
5. The nurse makes use of appropriate community resources, such as the Ileostomy Society, for additional assistance.

Standards of Maternal-Child Health Nursing Practice

Standard I - Maternal and child health nursing practice is characterized by the continual questioning of the assumptions upon which practice is based, retaining those which are valid and searching for and using new knowledge.

Rationale: Since knowledge is not static, all assumptions are subject to change. Assumptions are derived from knowledge of findings of research which are subject to additional testing and revision. They are carefully selected and tested and reflect utilization of present and new knowledge. Effective utilization of these knowledges stimulates more astute observations and provides new insights into the effects of nursing upon the individual and family. To question assumptions implies that nursing practice is not based on stereotyped or ritualistic procedures or methods of intervention; rather, practice exemplifies an objective, systematic and logical investigation of a phenomenon or problem.

Assessment Factors:

Therefore in practice, the Maternal and Child Health Nurse:

1. Critically examines and questions accepted modes of practice rather than relying on ritualistic or routined modes of practice.
2. Utilizes current and new knowledge in identifying and questioning validity of the assumptions which form the bases of nursing practice.
3. Continuously expands and improves nursing practice by utilizing theories and research findings in search of alternative solutions.
4. Actively shares new knowledge and approaches with colleagues and others in the community.

Standard II - Maternal and child health nursing practice is based upon knowledge of the biophysical and psychosocial development of individuals from conception through the childbearing phase of development and upon knowledge of the basic needs for optimum development.

Rationale: A knowledge and understanding of the principles and normal ranges in human growth, development and behavior are essential to Maternal and Child Health Nursing practice. Concomitant with this knowledge is the recognition and consideration of the psychosocial, environmental, nutritional, spiritual and cognitive factors that enhance or deter the biophysical and psychological maturation of the individual and his family.

Assessment Factors:

Therefore in practice, the Maternal and Child Health Nurse:

1. Observes, assesses and describes the developmental level and/or needs of the individual within the family before performing any actions.
2. Involves the individual and family in the assessment and planning of care.
3. Works with individuals and groups utilizing knowledge of the psychosocial, environmental, nutritional, spiritual and cognitive factors inherent in the family or group environment.

Standard III - The collection of data about the health status of the client/patient is systematic and continuous. The data are accessible, communicated and recorded.

Rationale: Comprehensive care requires complete and ongoing collection of data about the client/patient to determine the nursing care needs and other health care needs of the client/patient. All health status data about the client/patient must be available for all members of the health care team.

Assessment Factors:

1. Health status data include:
   - Growth and development
   - Biophysical status
   - Emotional status
   - Cultural, religious, socioeconomic background
   - Performance of activities of daily living
   - Patterns of coping
   - Interaction patterns
   - Client's/patient's perception and satisfaction with his health status
   - Client/patient health goals
   - Environment (physical, social, emotional, ecological)
   - Available and accessible human and maternal resources
2. Data are collected from:
   - Client/patient, family, significant others
   - Health care personnel
   - Individuals within the immediate environment and/or community
3. Data are obtained by:
   - Interview
   - Examination
   - Observation
   - Reading records, reports, etc.
4. Format for the collection of data:
   - Provides for a systematic collection of data
   - Facilitates the completeness of data collection

5. Continuous collection of data is evident by:
   - Frequent updating
   - Recording of changes in health status
6. The data are:
   - Accessible on the client/patient records
   - Retrievable from record-keeping systems
   - Confidential when appropriate

Standard IV - Nursing diagnoses are derived from data about the health status of the client/patient.

Rationale: The health status of the client/patient is the basis for determining the nursing care needs. The data are analyzed and compared to norms.

Assessment Factors:

1. The client's/patient's health status is compared to the norm to determine if there is a deviation, the degree and direction of deviation.
2. The client's/patient's capabilities and limitations are identified.
3. The nursing diagnoses are related to and comparable to the totality of the client's/patient's health care.

Standard V - Maternal and child health nursing practice recognizes deviations from expected patterns of physiologic activity and anatomic and psychosocial development.

Rationale: Early detection of deviations and therapeutic intervention are essential to the prevention of illness, to facilitating growth and development potential, and to the promotion of optimal health for the individual and the family.

Early detection requires that minute deviations be recognized, often before the individual or his family is aware that such deviations exist. The nurse has a unique opportunity to observe and assess the patient and his family, particularly in the community setting.

Assessment Factors:

Therefore in practice, the Maternal and Child Health Nurse:

1. Demonstrates a thorough understanding of the range of normal body structure and function by detecting signs and symptoms which are not within normal limits.
2. Identifies the variety of coping mechanisms which may serve an adaptive function or represent maladaptive patterns of response.
3. Searches for improved means of detecting impairment of physical and emotional function.

4. Searches for improved means of detecting physical, psychological or environmental situations which may lead to impaired functioning.
5. Informs the individual and family in recognizing and understanding deviations.

Standard VI - The plan of nursing care includes goals derived from the nursing diagnoses.

Rationale: The determination of the desired results from nursing actions is an essential part of planning care.

Assessment Factors:

1. Goals are mutually set with the client/patient and significant others:
   - They are congruent with other planned therapies.
   - They are stated in realistic and measurable terms.
   - They are assigned a time schedule for achievement.
2. Goals are established to maximize functional capabilities and are congruent with:
   - Growth and development
   - Biophysical status
   - Behavioral patterns
   - Human and material resources

Standard VII - The plan of nursing care includes priorities and the prescribed nursing approaches or measures to achieve the goals derived from the nursing diagnoses.

Rationale: Nursing actions are planned to promote, maintain and restore the client's/patient's well-being.

Assessment Factors:

1. Physical measures are planned to manage, prevent or control specific client/patient problems and clearly relate to the nursing diagnoses and goals of care, e.g. ADL, use of self-help devices, etc.
2. Psychosocial measures are specific to the client's/patient's nursing care needs and to the nursing care goals, e.g. techniques to control aggression.
3. Teaching-learning principles are incorporated into the plan of care and the objectives for learning stated in behavioral terms, e.g. specification of content for learner's level, reinforcement, readiness, etc.
4. Approaches are planned to provide for a therapeutic environment:
   - Physical environmental factors are used to influence the therapeutic environment, e.g. control of noise, control of temperature, etc.

5. Approaches are specified for orientation of the client/patient to:
   - New roles and relationships
   - Relevant health (human and material) resources
   - Modifications in the plan of nursing care
   - Relationship of the modifications in the nursing care plan to the total care plan
6. The plan includes the utilization of available and appropriate resources:
   - Human resources--other health professionals
   - Material resources
   - Community
7. The plan is an ordered sequence of proposed nursing actions.
8. Nursing approaches are planned on the basis of current knowledge.

Standard VIII - Nursing actions provide for client/patient participation in health promotion, maintenance and restoration.

Rationale: The client/patient and family are provided the opportunity to participate in the nursing care. Such provision is made based upon theoretical and experimental evidence that participation of client/patient and family may foster growth.

Assessment Factors:

1. The client/patient and family are kept informed about:
   - Current health status
   - Changes in health status
   - Total health care plan
   - Nursing care plan
   - Roles of health care personnel
   - Health care resources
2. The client/patient and family are provided with the information needed to make decisions and choices about:
   - Promoting, maintaining and restoring health
   - Seeking and utilizing appropriate health care personnel
   - Maintaining and using health care resources

Standard IX - Maternal and child health nursing practice provides for the use and coordination of all services that assist individuals to prepare for responsible sexual roles.

Rationale: People are prepared for sexual roles through a process of socialization that takes place from birth to adulthood. This process of socialization, to a large extent, is carried out within the family structure. Social control over child care increases in importance as humans become increasingly dependent on the culture rather than upon the family unit: The culture of any society is maintained by the transmission of its specific values, attitudes and behaviors from generation to generation. Attitudes and values

concerning male and female roles develop as part of the socialization process. Attitudes toward self, the opposite sex and parents will influence the roles each individual assumes in adulthood and the responsibility accepted.

Assessment Factors:

Therefore in practice, the Maternal and Child Health Nurse:

1. Utilizes resources available in the social and behavioral sciences to help her understand the attitudes and values of individuals and families with whom she is working.
2. Utilizes opportunities available to her to promote those attitudes and values conducive to emotional and physical health and family solidarity, without imposing her own values system.
3. Encourages society to provide the resources needed to help people prepare for responsible sexual roles.
4. Interprets to other health personnel the needs of individuals and families as she sees them and attempts to understand the needs as seen by other health personnel.
5. Works with other health personnel to develop services which promote optimal health and family solidarity.

Standard X - Nursing actions assist the client/patient to maximize his health capabilities.

Rationale: Nursing actions are designed to promote, maintain and restore health. A knowledge and understanding of the principles and normal ranges in human growth, development and behavior are essential to Maternal and Child Health Nursing practice.

Assessment Factors:

1. Nursing actions:
   - Are consistent with the plan of care.
   - Are based on scientific principles.
   - Are individualized to the specific situation.
   - Are used to provide a safe and therapeutic environment.
   - Employ teaching-learning opportunities for the client/patient.
   - Include utilization of appropriate resources.
2. Nursing actions are directed to the physical, psychological and social behavior associated with:
   - Ingestion of food, fluid and nutrients
   - Elimination of body wastes
   - Locomotion, exercise
   - Temperature and other regulatory mechanisms
   - Self-fulfillment
   - Relating to others

Standard XI - The client's/patient's progress or lack of progress toward goal achievement is determined by the client/patient and the nurse.

Rationale: The quality of nursing care depends upon comprehensive and intelligent determination of the impact of nursing upon the health status of the client/patient is an essential part of this determination.

Assessment Factors:

1. Current data about the client/patient are used to measure his progress toward goal achievement.
2. Nursing actions are analyzed for their effectiveness in goal achievement of the client/patient.
3. The client/patient evaluates nursing actions and goal achievement.
4. Provision is made for nursing follow-up of particular clients/patients to determine the long-term effects of nursing care.

Standard XII - The client's/patient's progress or lack of progress toward goal achievement directs reassessment, reordering of priorities, new goal setting and revision of the plan of nursing care.

Rationale: The nursing process remains the same, but the input of new information may dictate new or revised approaches.

Assessment Factors:

1. Reassessment is directed by goal achievement or lack of goal achievement.
2. New priorities and goals are determined and additional nursing approaches are prescribed appropriately.
3. New nursing actions are accurately and appropriately initiated.

Standard XIII - Maternal and child health nursing practice evidences active participation with others in evaluating the availability, accessibility and acceptability of services for parents and children and cooperating and/or taking leadership in extending and developing needed services in the community.

Rationale: Knowledge of services presently offered parents and children is the first step in determining the effectiveness of health care to all in the community. When it is recognized that needed services are not available, accessible or acceptable, the nurse takes leadership in working with consumers, other health disciplines, the community and governmental agencies in extending, and/or developing these services. Services must be continually evaluated, expanded and changed if they are to improve the health and well-being of all parents and children within our society.

Assessment Factors:

Therefore in practice, the Maternal and Child Health Nurse:

1. Applies and shares the cultural and socioeconomic concepts which help her understand the differences in the unique needs of individuals and families.
2. Recognizes the need for available health services for all parents and children in the community.
3. Utilizes the services and resources presently available.
4. Works with consumers, nurse colleagues, other health disciplines, the community and governmental agencies in evaluating the availability, accessibility and acceptability of services to all parents and children in the community.
5. Participates actively with significant others in initiating changes in the delivery of health services and/or developing new services to enable each individual in the family to function at his optimun capacity and to enhance family unity.

Standards of Psychiatric-Mental Health Nursing Practice

Standard I - Data are collected through pertinent clinical observations based on knowledge of the arts and sciences, with particular emphasis upon psychosocial and biophysical sciences.

Rationale: Clinical observation is a prerequisite to realistic assessment of a client's needs and for the formulation of appropriate intervention. Observations can be facilitated through knowledge derived from a broad general education. In addition, scholarship acquired in the study of psychosocial and biophysical sciences fosters acuity of perception and alerts the nurse to psychologic, cultural, social and other relevant clinical data.

Assessment Factors:

1. Data collecting activities involve observation, analysis and interpretation of behavior patterns of clients which indicate a need for growth promoting relationships.
2. Data collecting activities involve identification of significant areas in which clinical data are needed.
3. Data collecting activities involve utilization of knowledge derived from appropriate sources to gain a comprehensive grasp of the client's experience.
4. Data collecting activities involve inferences drawn from observations which contribute to a formulation of therapeutic intervention.
5. Data collecting activities involve inferences and treatment observations which are shared and validated with appropriate others.

Standard II - Clients are involved in the assessment, planning, implementation and evaluation of their nursing-care program to the fullest extent of their capabilities.

Rationale: To a very large degree, the therapeutic process is a learning process. The same principle that applies to learning also applies to therapy; that is, the learner or client must be an active participant in the process. The ability to participate in such a process will vary from person to person and, at times, even within the same person. The word "therapy" is used here in its broadest sense; that is, any behavior or planned activity that promotes growth and well-being. Thus, "nursing care program" and "nursing therapy" are interchangeably used, although it is recognized that many other forms of therapy exist.

Assessment Factors:

1. Clients' capabilities to participate at any given time are assessed, always keeping in mind the ultimate goals mutually determined by the client and nurse.
2. Plans for achieving and re-examining the goals are developed with the client, making whatever readjustments are necessary to progress toward them.
3. Problems are identified in collaboration with the client to determine needs and to set goals.
4. Progress of clients toward mutual goal achievement is assessed.

Standard III - The problem-solving approach is utilized in developing nursing care plans.

Rationale: A nursing diagnosis is based on pertinent theories of human behavior. It is used to plan therapeutic intervention taking into consideration the characteristics and capacities of the individual and his environment in order to maximize the treatment program for the client.

Assessment Factors:

1. The individual's reaction to the environment is observed and assessed.
2. Themes and patterns of the behavior are observed and assessed.
3. Nursing care plans are used as a guide to nursing intervention.
4. Nursing care plans are interpreted to professional and nonprofessional persons giving care.
5. Observations and reports of others are incorporated in the nursing care plans.
6. Nursing care plans are designed, implemented and reviewed systematically by the nursing staff.

Standard IV - Individuals, families and community groups are assigned to achieve satisfying and productive patterns of living through health teaching.

Rationale: Health teaching is an essential part of a nurse's role in work with those who have mental health problems. Every interaction can be utilized as a teaching-learning situation. Formal and informal teaching methods can be used in working with individuals, families, the community and other personnel. Emphasis is on understanding mental health problems as well as on developing ways of coping with them.

Assessment Factors:

1. The needs of individual, family and community groups for health teaching are identified and appropriate techniques are used in meeting these needs.
2. The principles of learning and teaching are employed.
3. The basic principles of physical and mental health and interpersonal and social skills are taught.
4. Experiential learning opportunities are made available.
5. Opportunities with community groups to further their knowledge and understanding of mental health problems are identified.

Standard V - The activities of daily living are utilized in a goal directed way in work with clients.

Rationale: A major portion of one's daily life is spent in some form of activity related to health and well-being. An individual's developmental and intellectual level, emotional state and physical limitations may be reflected in these activities. Therefore, nursing has a unique opportunity to assess and intervene in these processes in order to encourage constructive changes in the client's behavior so that each person may realize his full potential for growth.

Assessment Factors:

1. An appraisal is made of the client's capacities to participate in activities of daily living based on needs, strengths and levels of functioning.
2. Clients are encouraged toward independence and self-direction by various skills such as motivating, limit setting, persuading, guiding and comforting.
3. Each person's rights are appreciated and respected.
4. Methods of communicating are devised which assure consistency in approach.

Standard VI - Knowledge of somatic therapies and related clinical skills are utilized in working with clients.

Rationale: Various treatment modalities may be needed by clients during the course of illness. Pertinent clinical observations and judgements are made concerning the effect of drugs and other treatments used in the therapeutic program.

Assessment Factors:

1. Pertinent reactions to somatic therapies are observed and interpreted in terms of the underlying principles of each therapy.
2. A patient's responses are observed and reported.
3. The effectiveness of somatic therapies is judged and subsequent recommendations for changes in the treatment plan are made.
4. The safety and emotional support of clients receiving therapies is provided.
5. Opportunities are provided for clients and families to discuss, question and explore their feelings and concerns about past, current or projected use of somatic therapies.

Standard VII - The environment is structured to establish and maintain a therapeutic milieu.

Rationale: Any environment is composed of both human and nonhuman resources which may work for or against the person's well-being. The nurse works with people in a variety of environmental settings, e.g., hospital, home, etc. The milieu is structured and/or altered so that it serves the client's best interests as an inherent part of the overall therapeutic plan.

Assessment Factors:

1. The effects of environmental forces on individuals are observed, analyzed and interpreted.
2. Psychological, physiological, social, economical and cultural concepts are understood and utilized in developing and maintaining a therapeutic milieu.
3. Communications within the environment are congruent with therapeutic goals.
4. All available resources in the environment are utilized when appropriate in the therapeutic efforts.
5. Nursing participation and its effectiveness in establishing and maintaining a therapeutic milieu are evaluated.

Standard VIII - Nursing participates with interdisciplinary teams in assessing, planning, implementing and evaluating programs and other mental health activities.

Rationale: In addition to the nurse, the number and variety of people working with clients in the mental health field today make it imperative that efforts be coordinated to provide the best total program. Communication, planning, problem-solving and evaluation are required of all those who work with a particular client or program.

Assessment Factors.

1. Specific knowledge, skills and activities are identified and articulated so these may be coordinated with the contributions of others working with a client or a program.
2. The value of nursing and team member contributions are recognized and respected.
3. Consultation with other team members is utilized as needed.
4. Nursing participates in the formulating of overall goals, plans and decisions.
5. Skills are developed in small group process for maximum team effectiveness.

Standard IX - Psychotherapeutic interventions are used to assist clients to achieve their maximum development.

Rationale: People with mental health problems fashion many of their patterns of living and relating to others on a psychopathologic basis. In order to help clients achieve better adaption and improved health, a nurse assists them to identify that which is useful and that which is not useful in their modes of living and relating. Alternatives available to them are identified.

Assessment Factors:

1. Useful patterns and themes in the client's interactions with others are re-enforced.
2. Clients are assisted to identify, test out and evaluate more constructive alternatives to unsatisfactory patterns of living.
3. Principles of communication, problem-solving, interviewing and crisis intervention are employed in carrying through psychotherapeutic intervention.
4. Knowledge of phychopathology and its health adaptive counterparts are used in planning and implementing programs of care.
5. Limits are set on behavior that is destructive to self or others with the ultimate goal of assisting clients to develop their own internal controls and more constructive ways of dealing with feelings.
6. Crisis intervention is used to reduce panic of disturbed patients.
7. Long-term psychotherapeutic relationships with clients are undertaken.
8. Colleagues are utilized in evaluating the progress of the psychotherapeutic relationships and in formulating modification of intervention techniques.
9. Nursing participation in the therapeutic relationship is evaluated and modified as necessary.

Standard X - The practice of individual, group or family psychotherapy requires appropriate preparation and recognition of accountability for the practice.

Rationale: Acceptance of the role of therapist entails primary responsibility for treatment of clients and entrance into a contractual agreement. This contract includes a commitment to see a client through the problem he presents or, if this becomes impossible, to assist him in finding other appropriate assistance. It also includes an explicit definition of the relationship, the respective roles of each person in the relationship, and what can realistically be expected of each group.

Assessment Factors:

1. The potential of the nurse to function as a primary therapist is evaluated.
2. The accountability for practicing psychotherapy is recognized and accepted.
3. Knowledge of growth and development, psychopathology, psychosocial systems and small group and family dynamics is utilized in the therapeutic process.
4. The terms of the contract between the nurse and the client, including the structure of time, place, fees, etc., that may be involved, are made explicitly clear.
5. Supervision or consultation is sought whenever indicated and other learning opportunities are used to further develop knowledge and skills.
6. The effectiveness of the work with an individual, family or group is routinely assessed.

Standard XI - Nursing participates with other members of the community in planning and implementing mental health services that include the broad continuum of promotion of mental health, prevention of mental illness, treatment and rehabilitation.

Rationale: In our contemporary society, the high incidence of mental illness and mental retardation requires increased effort to devise more effective treatment and prevention programs. There is a need for nursing to participate in programs that strengthen the existing health potential of all members of society. In this effort cooperation and collaboration by all community agencies becomes imperative. Such concepts as early intervention and continuity of care are essential in planning to meet the mental health needs of the community. The nurse uses organizational, advisory or consultative skills to facilitate the development and implementation of mental health services.

Assessment Factors:

1. Knowledge of community and group dynamics is used to understand the structure and function of the community system.

2. Current social issues that influence the nature of mental health problems in the community are recognized.
3. High risk population groups in the community are delineated and gaps in community services are identified.
4. Community members are encouraged to become active in assessing community mental health needs and planning programs to meet these needs.
5. The strength and capacities of individuals, families and the community are assessed in order to promote and increase the health potential of all.
6. Consultative skills are used to facilitate the development and implementation of mental health services.
7. The needs of the community are brought to the attention of appropriate individuals and groups, including legislative bodies and regional and state planning groups.
8. The mental health services of the agency are interpreted to others in the community. There is collaboration with the staff of other agencies to insure continuity of service for patients and families.
9. Community resources are used appropriately.
10. Nursing participates with other professional and nonprofessional members of the community in the planning, implementation and evaluation of mental health services.

Standard XII - Learning experiences are provided for other nursing care personnel through leadership, supervision and teaching.

Rationale: As leader of the nursing team, the nurse is responsible for the team's activities, and must be able to teach, supervise and evaluate the performance of nursing care personnel. The focus is on the continuing development of each member of the team.

Assessment Factors:

1. Leadership roles and responsibilities are accepted.
2. Team members are encouraged to identify strengths and abilities. A climate is provided for the continuing self-development of each member.
3. A role model in giving direct nursing care is provided for the team.
4. The supervisory role is used as a tool for improving nursing care.
5. The client's needs, as well as the abilities of each member of the nursing team, are evaluated and assignments are based on these evaluations.

Standard XIII - Responsibility is assumed for continuing educational and professional development and contributions are made to the professional growth of others.

Rationale: The scientific, cultural and social changes characterizing our contemporary society require the nurse to be committed to the ongoing pursuit of knowledge which will enhance professional growth.

Assessment Factors:

1. There is evidence of study of one's nursing practice to increase both understanding and skill.
2. There is evidence of participation in in-service meetings and educational programs either as an attendee or as a teacher.
3. There is evidence of attendance at conventions, institutes, workshops, symposia and other professionally oriented meetings and/or other ways to increase formal education.
4. There is evidence of systematic efforts to increase understanding of psychodynamics, psychopathology and avenues of psychotherapeutic intervention.
5. There is evidence of cognizance of developments in relevant fields and utilization of this knowledge.
6. There is evidence of assisting others to identify areas of educational needs.
7. There is evidence of sharing appropriate clinical observations and interpretations with professionals and other groups.

Standard XIV - Contributions to nursing and the mental health field are made through innovations in theory and practice and participation in research.

Rationale: Each professional has responsibility for the continuing development and refinement of knowledge in the mental health field through research and experimentation with new and creative approaches to practice.

Assessment Factors:

1. Studies are developed, implemented and evaluated.
2. Responsible standards of research are used in investigative endeavors.
3. Nursing practice is approached with an inquiring and open mind.
4. The pertinent and responsible research of others is supported.
5. Expert consultation and/or supervision is sought as required.
6. The ability to discriminate those findings which are pertinent to the advancement of nursing practice is demonstrated.
7. Innovations in theory, practice and research findings are made available through presentations and/or publications.

Standards of Medical-Surgical Nursing Practice

Standard I - The collection of data about the health status of the patient is systematic and continuous. These data are communicated to appropriate persons recorded and stored in a retrievable and accessible system.

Data are obtained by interview, physical examination, review of records and reports, and consultation.

Priority of data collection is determined by the immediate physical condition of the patient.

Assessment Factors:

1. Health data include, but are not limited to:
   a. The patient's perceptions and expectations which are related to health care services;
   b. Current medical diagnosis and therapy.
   c. Environmental, occupational, recreational and spiritual information as it relates to the patient's habits;
   d. Information about previous use of health services;
   e. The patient's mental and emotional responses;
   f. Assessment of function and status in the following areas:
      - cardiovascular and respiratory
      - gastrointestinal
      - fluid and electrolyte balance
      - kidney and bladder
      - neuromuscular
      - sensory
      - integumentary
      - sexuality and reproductive
      - metabolic regulation
      - sleep, rest, comfort
      - immunological and hemopoietic
2. Health data are collected by appropriate methods.
3. Health data collection is complete.

Standard II - Nursing diagnosis is derived from health status data.

Nursing diagnosis is a concise statement identifying the patient's problem(s). It is not a summary of all abnormalties.

Assessment Factors:

1. The nursing diagnosis is based upon identifiable data.
2. Health status deviation(s) is determined by comparing the identified data to establish norms and/or the patient's previous condition.
3. Nursing diagnosis is consistent (as far as possible) with current knowledge.

Standard III - Goals for nursing care are formulated.

A goal is the end state toward which nursing action is directed.

Assessment Factors:

1. Goals are derived from nursing diagnosis.
2. Goals are stated in terms of observable outcomes.
3. Goals are formulated by the patient, his family, health personnel and significant others.
4. Goals are congruent with the patient's present and potential physical capabilities and behavioral patterns.
5. Goals are attainable through available human and material resources.
6. Goals are achievable within an identifiable time frame.

Standard IV - The plan for nursing care prescribes nursing actions to achieve the goals.

The plan for nursing care describes a systematic method to meet the goals.

Assessment Factors:

1. The plan includes priorities for nursing actions.
2. The plan includes a logical sequence of actions to attain the goals.
3. The plan is based on current scientific knowledge.
4. The plan incorporates available and appropriate resources.
5. The plan can be implemented.
6. The plan reflects the consideration of the "Patient's Bill of Rights."
7. The plan specifies the following:
   - what is to be done
   - how to do it
   - when to do it
   - where to do it
   - who is to do it
8. The plan is communicated to patient, family, significant others and health personnel as appropriate.

Standard V - The plan for nursing care is implemented.

The plan must be applied to achieve the goals.

Assessment Factors:

1. Nursing actions can be documented by written records, observation of nursing performance and/or patient report(s) of nursing actions.
2. Nursing actions are consistent with the plans for nursing care.

Standard VI - The plan for nursing care is evaluated.

Patient response is compared with observable outcomes which are specified in the goals.

Assessment Factors:

1. Current data about the patient are used to measure progress toward goal achievement.
2. The patient, family, health personnel and significant others contribute to the evaluation of goal achievement.
3. The degree of goal achievement is communicated by the nurse to the patient, family, significant others and health personnel.

Standard VII - Reassessment, reordering of priorities, new goal setting and revision of the plan for nursing care are a continuous process.

The steps of the nursing process are used concurrently and recurrently.

Assessment Factors:

1. Reassessment is directed by goal achievement and/or new data.
2. Ongoing documentation is consistent with the time frame specified in the goals.
3. Current goals are consistent with evaluation of the patient's progress.

APPENDIX B

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August 21, 1975

Dr. Gertrude M. Enloe
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Dear Dr. Enloe:

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Sincerely,

Juanita M. Ramos

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